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MENTAL HEALTH INITIATIVE

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

ON

OVERSIGHT HEARING ON A COMMUNITY-BASED MENTAL HEALTH INITIATIVE FOR INDIAN PEOPLE

JULY 7, 1988
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MENTAL HEALTH INITIATIVE FOR INDIAN PEOPLE

THURSDAY, JULY 7, 1988

U.S. Senate,
Select Committee on Indian Affairs,
Washington, DC.

The committee met, pursuant to notice, at 1:34 p.m., in room 485, Russell Senate Office Building, Hon. Thomas A. Daschle (acting chairman of the committee) presiding.

Present: Senators Daschle and Evans.

STATEMENT OF HON. THOMAS A. DASCHLE, U.S. SENATOR FROM SOUTH DAKOTA

Senator Daschle. The committee will come to order.

The Chairman, Senator Inouye, is currently occupied on the floor of the Senate, and will not be able to begin the hearing, as much as he would like to be here. He will be here shortly, just as soon as the bill has been disposed of. But, in any case, we will begin the hearing and, as other members come, I am sure we can expect greater participation this afternoon.

[Prepared statement of Senator Inouye follows:]

Statement of Hon. Daniel K. Inouye, U.S. Senator From Hawaii, Chairman, Select Committee on Indian Affairs

This hearing is being held to receive testimony on the status of mental health in the Native American population, to develop an understanding of what efforts are being undertaken nationwide to address mental health problems in the Indian population, and to examine the need for a comprehensive community-based mental health initiative.

It is widely acknowledged that there is a critical lack of direct research into the normal physiological, neurosensory, cognitive, emotional, social, and cultural development of the Indian child from birth to five years of age, in terms of how development in these areas contributes to positive and successful mental health functioning. Mental health research of Indian adolescent and adult populations is sparse, at best. What we do know is this: The age-adjusted mortality rate from suicide for American Indians and Alaska Natives exceeds that of other non-white U.S. populations by 200 percent; the age-adjusted homicide rate among Native Americans exceeds the rate for all races within the United States by 170 percent; the age-adjusted alcoholism death rates as compared to all races within the United States is 480 percent higher in the Native American population.

We know, too, from documents such as the President's Budget Justification for the Indian Health Service for Fiscal Year 1989 that: "The significant reduction over the past few years in the morbidity and mortality rates for many of the physical health problems affecting Indian populations has not been paralleled in the mental health area. On the contrary, many believe that mental health problems in American Indians and Alaska Natives have become more serious and more numerous in recent years." Yet competing priorities for resources continue to result in funding for mental health programs that is far from adequate to meet the growing needs.

Compounding the problems of inadequate research and insufficient resources are other differences, that an Indian psychologist has aptly identified: "Differences in culture result in a lack of cultural understanding by non-Indian providers, lack of trust, and rapport between Indians and non-Indians, lack of contact and relationship with the Indian community by professionals * * *. Differences in socioeconomic status result in the inability of Indian consumers to cover the costs of mental health services, insufficient funds for adequate mental health programs * * * and in general, reduce the accessibility of mental health services for Indian persons. Differences in geography (both residence and location) result in problems of transportation and distance, lessened familiarity with available resources (less felt input and ownership) by Indian people, fewer and less available trained staff on the reservation * * *. Differences in language impede communication, as does the lack of understanding of mental health terminology, and the language of therapy * * *. Differences in educational level result in a lack of knowledge about the concept of mental health by Indian consumers * * *. Lack of trained Indian personnel * * * and because of the history of past relationships with non-Indian social services and legal systems, potential Indian consumers may be realistically afraid of losing rights as free individuals and as guardians of their children."

What kinds of mental health services and programs, research and treatment are being developed on a national scale for all American citizens, and which of those activities are targeted for addressing the needs of Indian Americans? How does the Department of Health and Human Services coordinate the efforts of its various agencies—the Alcohol, Mental Health and Drug Abuse Administration; the National Institute for Mental Health; the Division of Maternal, Child and Adolescent Health; the Office of Minority Affairs; the Indian Health Service—to serve the Native American population? What is being done in the private sector and in Indian communities to address mental health care needs? We are here today to seek the answers to these questions, and to examine the need for a comprehensive community-based mental health initiative.

Senator **Daschle**. And so I welcome all of you in participation this afternoon. I invite each of our panelists to come forth and present their testimony as they see fit, and invite our first panel to come at this time. That panel is composed of witnesses from the Department of Health and Human Services, and I invite them to come forth now.

That panel is composed of Dr. Craig Vanderwagen, Dr. Scott Nelson, Mr. Henry Montes, Dr. Delores Parron, and Dr. David Heppel.

Panelists, we are pleased that you could join us. I don't know whether any pecking order has been decided among you, but we invite you to proceed and are glad you are here.

STATEMENTS OF CRAIG VANDERWAGEN, M.D., DIRECTOR, DIVISION OF CLINICAL AND PREVENTION SERVICES, INDIAN HEALTH SERVICE, ROCKVILLE, MD; SCOTT NELSON, M.D., CHIEF, MENTAL HEALTH PROGRAMS BRANCH, OFFICE OF HEALTH PROGRAMS, ROCKVILLE, MD; HENRY MONTES, ASSOCIATE DIRECTOR, OFFICE OF MINORITY HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC; DELORES PARRON, ASSOCIATE DIRECTOR FOR SPECIAL POPULATIONS, NATIONAL INSTITUTE OF MENTAL HEALTH, ROCKVILLE, MD; AND DAVID E. HEPPEL, CHIEF, CHILD-ADOLESCENT PRIMARY CARE SERVICES, DIVISION OF MATERNAL, CHILD HEALTH AND RESOURCES DEVELOPMENT, HRSA, ROCKVILLE, MD

Dr. **Vanderwagen**. Thank you, Mr. Chair.

I am Dr. Craig Vanderwagen. I am the Director of the Division of Clinical and Prevention Services with Indian Health Service, and I am here today with Dr. Scott Nelson, who is the Director of our

Mental Health Program. We also have with us today—you will be hearing from later—Ms. Phyllis Old-Dog Cross, who is with our Inpatient Unit in Rapid City, and Dr. Marion Zonnis, who is with the IHS Navajo Area. And, as you mentioned, we have various representatives of the Public Health Service with us today: Dr. Delores Parron, who is the Associate Director of Special Populations for the National Institute of Mental Health; Dr. David Heppel, who is the Director of the Division of Maternal and Child Health in HRSA; and Mr. Henry Montes, who is the Assistant Director of the Office of Minority Health. The Centers for Disease Control was unable to send a representative today, but if you have any questions regarding CDC we will be happy to submit written responses.

We are submitting our written statements as one package together, and I'll begin to summarize the piece that I have, and then I would like to turn over to Dr. Nelson and the others in the panel.

We in Indian Health Service believe there is a significant upheaval in American Indian and Alaska Native communities. It is characterized, as you have described it in many ways, by a disruption of the social fabric, and it manifests as a set of behavioral problems that feeds a spiral of failure that affects both individuals and the community as a whole. It is recognizable by the problems of chemical dependency and abuse, suicide, homicide, and family violence. You have characterized that very effectively to describe what we view as the epidemiologic situation which we confront.

These health problems have reached a critical point in American Indian and Alaska Native communities. The medical care system so painstakingly built to address the scourge of TB, trauma, child birth, childhood illness, and other health problems has been very successful in addressing many of its targeted medical goals. The core of IHS functions is maintaining and improving the health status of American Indians and Alaska Natives, and this medical model has a most significant role. However, behavioral health issues require a different focus, and cannot effectively be addressed without community leadership and direction. The community can and must identify the issues and approaches to resolution of these health problems. The IHS can and must be an effective helping resource for community efforts, but we believe that the community is in the controlling role in this environment, not IHS. We are a resource at their disposal, and we would like to see them in the driver's seat. We would like to see them direct this activity.

How can we be an effective resource to support these community initiatives? Well, I believe that examples of this might be found in the activities of the alcohol and substance abuse programs of the IHS. The IHS has provided technical assistance in the development of school-based and community-based prevention activities. These are described in a recent publication which we will submit to you for the record. The IHS is collaborating with a variety of private institutions to provide training for tribal staff to expand the knowledge and expertise within the community to address substance abuse issues. At the direction of tribal coordinating committees, IHS has funded training for tribal staffs, tribal leadership, and other community members. Service delivery has also been significantly modified based upon input and direction from the communities. The alcohol action plan that was developed a couple of years ago is based upon significant tribal participation. An interagency initiative undertaken at the direction of Secretary Bowen has led to strong and vital coordination of departmental resources in this area.

These are all examples from the Alcohol and Substance Abuse Program. These efforts were based upon both Legislative and Executive Branch commitment to reducing chemical abuse and dependency in American Indian and Alaska Native communities, and the same sorts of programs that need strengthening are already beginning in the mental health activity. The special initiatives team of the mental health program has begun to provide technical assistance and support, and in this last year they visited and worked with 43 different Indian communities, and we have gotten much positive feedback from the communities. This approach to planned community response to mental health issues holds great promise, but it is only the beginning, and we believe that and Executive Branch initiative is called for.

The witnesses on our panel represent various components of the Public Health Service. The written materials and comments submitted by this group reflect their activities both independently and collaboratively, and the enhancement of these activities in assuring the most effective availability of Federal resources in American Indian and Alaska Native communities is the goal of the IHS Mental Health program.

Dr. Nelson will provide you with a more specific description of the Mental Health program activities as they exist today.

Dr. **Nelson**. Thank you, Mr. Chairman and members of the committee.

I am Dr. Scott Nelson. I am a psychiatrist and Chief of the Mental Health Programs with the Indian Health Service. I am pleased to be here today to discuss with you our Mental Health Program effort.

The mission of the IHS mental health system is to provide access for all American Indian and Alaska Native persons to mental health services which are appropriate to the nature and severity of their mental illnesses, which are high quality, and which are sensitive and responsive to the cultural values of the individual, the individual's family and community.

Our Mental Health Branch is located in Rockville, MD. It's part of the IHS. Our staff work closely with tribes, IHS Area and Service Unit staff, relevant Health and Human Services and BIA components, and major Indian organizations on mental health issues.

Each of our 12 IHS Area offices has a full or part-time mental health consultant available. Some of these consultants also deal with social services and substance abuse. The Area offices allocate mental health funds to the service units and tribal programs. They provide technical assistance and consultation to local communities and other Area staff, and they monitor and review mental health programs.

At the community level, delivery of mental health services is a responsibility of the local Service Units, 75 percent which are operated directly by Indian Health Service, and the others are part of tribally administered programs. We are happy to report that the tribes are increasingly assuming the responsibility for directly operating mental health service programs pursuant to the provisions of Public Law 93-638.

In terms of some of the issues and problems that we encounter in the field, studies indicate that depression is clearly the emotional problem that occurs most frequently in Indian communities, both in adults and in children. Usually this is related to life events, such as death, serious injury, economic issues, marital disharmony, which are commonly found in Indian country. Often, I think, depression is a result of acculturation pressures or of long-standing low self-esteem related to childhood experiences of neglect and/or physical, sexual, or emotional abuse.

Depressed feelings are frequently complicated by use of alcohol or other drugs, and the combination of low self-esteem, alcohol and the frustration of life circumstances unfortunately leads frequently to suicide, violence, or other forms of abuse.

As you have stated, Mr. Chairman, suicide, homicide, and accidental death occur much more frequently among Indian people than in the general population. The rate of death from suicide, homicide and accidents in young Indian males is more than twice the national average. Many of the accidental deaths are associated with known depression and alcohol use, and are suspected to be suicides.

We do see other common problems in the mental health service programs, including anxiety, phobias, uncomplicated alcoholism. It is unclear to us why some of the more serious disorders in some tribes appear to be less frequent, such as schizophrenia and manic-depressive illness, and I think we need to study those diagnostic categories further.

About 80 percent of our 127 IHS Service Units have implemented a formal mental health service program. The most common program model is an outpatient service which is staffed by one or more mental health professionals, often with the assistance of a local American Indian or Alaska Native mental health technician. On-call emergency mental health services are also provided outside of usual clinic or hospital hours. Consultation is also provided to medical staff on mental health problems and to other service unit and tribal programs within staffing constraints. Specialized mental health services for populations such as children and the elderly are minimal to non-existent because of limited resources and difficulties in recruitment of trained specialists.

Inpatient services are available through a variety of mechanisms in most of the Service Units. Some IHS hospitals can accommodate non-violent psychiatric patients for a few days with the continued involvement of the mental health professional staff, but more commonly, inpatient services are provided under contract with local general hospital psychiatric units or with private psychiatric hospitals. Often, emergency hospitalizations and hospitalizations of long duration are provided by State mental hospitals.

Our Indian Health Service operates two short-term psychiatric hospital inpatient units. One has 14 beds at the Gallup Indian Medical Center in Gallup, New Mexico, and the other is 9 beds in the Public Health Service Hospital in Rapid City, South Dakota. Ms. Cross, I am sure, will be glad to comment on her experience in Rapid City, later on. These units serve Indian persons from adjacent Areas and are almost always at capacity, and they almost always have waiting lists for admission.

It should be mentioned that Native healers provide services in most American Indian and Alaska Native communities. These services clearly complement Western methods of psychological care and are often fully sufficient to resolve situations involving emotional distress.

It should be noted that in many Areas, State or local community mental health programs also provide services to Indian persons with emotional problems. Partial hospitalization, transitional living, and child residential mental health programs are obtained from local or State resources when they are available.

In the area of funding, in most Areas, the majority of funding for mental health services is provided by the line-item categorical appropriation for mental health services in the IHS budget. In the current fiscal year, that appropriation is $12.466 million. The President's budget proposal for fiscal year 1989 for IHS Mental Health Services is $13.091 million, an increase of $625,000.

Some Service Units use other sources of funds to purchase mental health services. These include hospital and clinic or contract health service funds. And, as I mentioned, States and localities often provide services as well to Indian people. However, many times Indian people do not use State or local services because there is a perceived lack of sensitivity to Indian people and Indian traditions.

We are placing increased emphasis on collection of third party revenues by mental health service programs and by service units generally, and some Indian persons do carry insurance and many others are eligible for Medicaid or Medicare reimbursement.

In terms of staffing, as of last September, the Areas reported 269 staff funded by mental health categorical funds. Of the 269 staff, 221 were direct service staff, and 48 were administrative or clerical. Of the 221 direct service staff, 70 were Indian mental health technicians, 61 were social workers, 48 were psychologists, and 42 of those were doctoral level psychologists, 24 were psychiatrists, 8 were nurses, and 10 were members of other disciplines. 188 of the direct treatment staff are employed by IHS and 33 are employed by tribes, and an estimated 40 to 50 additional staff are employed by tribes through contract or direct tribal funding. The estimated total of about 260 to 270 staff throughout the country means that, on the average, there are about two mental health direct treatment personnel available for each of the 127 Service Units, more or less.

In summary, most IHS Service Units do provide mental health services through an ambulatory mental health service program, and arrange for inpatient services through contracts or arrangements with State mental hospitals.

Our national mental health staff are working closely with tribes and local Service Units to improve the mental health program within the resources available. Our major current activities include: an active quality assurance program, which includes reviews of mental health programs pursuant to our recently promulgated IHS mental health standards; a team of professionals which is available for consultation to tribes, IHS and other field personnel regarding strategies for prevention of suicide and other forms of violent behavior; and increased planning efforts, including the development of a national mental health plan and an American Indian and Alaska Native—mental health Research Agenda, and both of these are under preparation, in consultation with the field.

We remain committed to providing the highest possible mental health care within the resources available to us.

That concludes my statement. I will be glad to try to answer any questions that the committee may have.

Senator **Daschle**. Thank you, Dr. Nelson.

Dr. **Parron**. I am Delores Parron, Associate Director for Special Populations, the National Institute of Mental Health. We have submitted a full statement for the record, but I wanted to highlight some of the activities in NIMH that are addressing the needs of American Indians and Alaska Natives.

As we look at our portfolio in NIMH, we see the recent activities across the board in research, in mental health services, in research training, and in clinical training.

In the research area, we can look to about $1.5 million in research directly targeting American Indian and Alaska Native population. The centerpiece of this research effort, is the research center supported by the NIMH at the University of Colorado Health Sciences Center, the American Indian and Alaska Native Mental Health Research Center that is headed by Dr. Spero Manson. In fiscal year 1987, the center received funding in the amount of $409,592. In fiscal year 1987, we also supported four other studies of the American Indian population for more than $1 million.

In the services area, exercising our national leadership role since NIMH has had the lesser role in the direct funding of mental health services, we have developed the Child and Adolescent Service System Program and the Community Support Program. In both of these, in cities and States in the West, where there are significant Indian populations, we can point to some very interesting and ongoing activities.

In the area of research training, because one of the things we know is that it does take sometimes a person from a particular group to do the kind of critical thinking for good research on a particular population, we can look at our Minority Fellowship Program, which provides support for doctoral level training for minorities. In that program we have three American Indians who are in the course of pursuing doctoral level training to do research, hopefully on their own population, and one young person in our Minority Access to Research Careers program, which is an undergraduate program. We are trying to help this young person not only through their undergraduate degree program, but also interest them in a career in mental health research.

In clinical training, I can say that by the end of fiscal year 1988, we will be funding six programs that are directed toward developing American Indian clinicians or toward the development of curriculums that can sensitize others to work effectively with American Indian populations. Those programs are in psychology, social work, and in psychiatric nursing.

Senator **Daschle**. Thank you, Dr. Parron.

Are there any additional formal statements?

Mr. MONTES. Yes; my name is Henry Montes, Mr. Chairman. I am the Associate Director for external programs for the Office of Minority Health.

I thought I would take this moment to speak because our office is relatively new, and unlike the NIMH and the MCH programs that have been around for quite awhile, our office has only been around since December of 1985. The Office of Minority Health was established in response to the Secretary's Task Force on Black and Minority Health to ensure the implementation of the recommendations of that voluminous report.

The four minority groups that were studied included Asians Pacific Islanders, Blacks, Hispanics, and Native Americans, including American Indians, Alaskan Natives and Native Hawaiians.

We have been working with the Indian Health Service, through a formal established Memorandum of Understanding. To give you an introduction to the purposes of our office, our staff is relatively small, and it is really policy-oriented. It is a program coordinative and advocacy office within the Department to ensure that minorities' health agenda is high on the priority list of the programs within the Department.

To do that, we have taken steps both internally and externally to coordinate various health problem areas that exist within these minority groups that were identified by the Secretary's Task Force Report. There were six health problem areas identified that accounted for more than 80 percent of excess deaths in minorities. Of these six, chemical dependency and violence, which includes homicide, suicide, and unintentional injuries or accidents, are prominent for the minority populations and especially Native Americans. Thus, these two problem areas are where our concern is greatest with regard to identifying the problems in the Native American populations that is American Indian and Alaskan Native populations.

Besides having a public health dimension, it is these particular health problem areas where we feel we must try to address the entire person in the context of his/her life. We are basically trying to stimulate a prevention concept within the minority community. One method that we have taken to do this is to develop a community-based coalition demonstration grant program. From the first round of this grant program, two of our grantees dealt with American Indians, one with the Seattle Indian Health Board and a coalition of ten tribes and two other urban Indian sites in the Puget Sound Indian Health Service Unit Area; and two with Robeson County, North Carolina, with the Lumbie and Tuscarora Indian Tribes, who are not officially recognized Indian tribes in that area.

The Seattle project deals with adult children of alcoholics (ACOA) I see on the list of persons who will be testifying this afternoon that the Executive Director is here and can give you more information about that particular project.

The project that we funded in North Carolina is an unintentional injury prevention program geared at the American Indian and the black populations in that county. Essentially it is community-based, by coordinating the efforts of several agencies to address the high injury rate in Robeson County. The Principal Investigator is an American Indian woman who is very familiar with, not only the health problem areas with regard to the population, but also the sociopolitical issues that have existed in that particular county.

One last thing I would mention is that, in order to ensure that there is a continuity of concern over minority health, which, obviously, will include the Native Americans, within the planning and program development of the Department, we are in the process of developing a long-range strategic plan as well as minority health objectives for the year 2000, in concert with the Department's prevention objectives for the year 2000. We coordinate these efforts through participation on the Department Steering Committee, and through nine health issue working groups whose members are from different departmental agencies.

Senator DASCHLE. Thank you, Mr. Montes.

[Prepared statement of Dr. Vanderwagen appears in appendix.]

Senator DASCHLE. I appreciate this testimony provided, and commend you for your excellent statements. I can't help, having read my opening statement, which was, obviously, the product of a tremendous amount of research by the Indian Committee Staff, the statistics that are so striking, the age-adjusted homicides, 170 percent greater than those outside of Native Americans. Age-adjusted alcoholism, 480 percent. The mortality, 200 percent greater.

Mental health is so pervasive in the population that it troubles me to hear, Dr. Vanderwagen, that, in spite of its pervasive nature, in spite of these statistics, Indian Health Service this year is going to have $13 million to deal with mental health, and you've got 23 beds? I assume you are talking about the entire nation.

Dr. VANDERWAGEN. Correct.

Senator DASCHLE. We have 23 beds in the whole country.

Dr. VANDERWAGEN. That's correct.

Senator DASCHLE. To deal with this issue.

What kind of a response is that, from an agency, when you see statistics as significant as the ones you and I both addressed?

Dr. VANDERWAGEN. Well, sir, you know, we are funded, as you are aware, to provide a comprehensive health program, and I think the issues of infant child health, maternal and child health, a number of other issues like that, has historically captured our attention and captured the resource to address those issues, and I think over the last year or two, and again, you quoted the 1989 President's budget submission. I think we've begun to recognize in the last couple of years that, while we may be making significant progress in these other areas, there's a whole unaddressed set of issues that lie before us in the mental health arena.

And again, we welcome this opportunity to talk with you all about how might we best address that, and looking at the competing priorities that we have within Indian communities and within the national system.

Senator DASCHLE. How do you prioritize now? What is it that would bring the IHS to the conclusion that for Indian health we spend one percent, for other programs we spend greater degrees of what resources you have? Why is it in this case that mental health is only one percent?

Dr. VANDERWAGEN. Well, sir, I believe that's because the resource has been line-item appropriated, and I think we have taken the approach that the hospitals and clinics is being demanded for acute trauma, the care of people who have been in automobile accidents, the care for people who have cirrhosis, the care of battered children that come through the hospital, and the staffing requirements in providing that acute medical service has been all-consuming, and that the kind of community-based prevention, of family intervention, that we think really do require additional resource analysis and resource consideration, we have a choice there between leaving those acute care issues that present themselves in the emergency room, demanding, needing, and appropriately should get care versus should we take some of the funds from that activity and put it into this mental health activity that clearly is a pressing need.

And I think it has been very difficult for us to turn away people at the emergency room, to turn away people from the labor and delivery suite, turn away people from the hospital beds that we have in order to seek, you know, move our funding from that activity over to mental health.

Senator DASCHLE. What percent of the budget for IHS actually goes to direct benefit of the Indian population, and what percent is used in the administration of those programs?

Do you have that available?

Dr. VANDERWAGEN. I would be happy to submit a more complete response to that for the record, but I think the most recent data analysis that we have seen depend upon whether you are talking headquarters, or you are talking area offices, and I think the overhead generally that we're looking at is 12 to 13 percent.

Senator DASCHLE. The entire national overhead, out of the IHS budget, 12 to 13 percent is on administration and 88 percent, roughly, is spent in direct benefit to Indian people?

Dr. VANDERWAGEN. Generally I would say that is true. Again, we can provide more comprehensive figures, perhaps, an analysis to that, for the record.

Senator DASCHLE. What specific effort is IHS making now to address some of them in a more general fashion? But can you identify efforts made by not only the IHS, the tribes, and Indian organizations to work with the States in addressing mental health needs?

Dr. NELSON. Well, I think that that varies a great deal. Alaska, for example, is doing an extremely good job with regard to that. 90 percent of the funding for Indian mental health programs in Alaska comes from the State.

I think most States have been really quite cooperative in terms of making full access of services available to Indian people. There are some States where it tends to be a little more difficult, either in terms of access to outpatient or access to inpatient. And I think that is a matter of mostly our Areas being in close touch with the mental health officials in that State. Sometimes it's a larger issue and a policy issue within the State, and I think requires some larger working.

Senator DASCHLE. Can you cite some specifics in areas outside of Alaska? Obviously, with Native Alaskans you have a different set of experiences and circumstances than you do in Continental United States. What can you cite there? Any specific examples within the States themselves where you can demonstrate an effective IHS interface with the States and what they're doing?

Dr. **Nelson**. I think that there have been effective interfaces, for example, in Oklahoma. You're talking about effective ones?

Senator **Daschle**. Yes.

Dr. **Nelson**. I think New Mexico is quite willing, for example, to hospitalize Indian people at the State hospital, and does not charge the tribes or the Indian Health Service. Examples like that I would say are more the rule rather than the exception. But there are exceptions to that in two or three States.

Senator **Daschle**. What monitoring system do you have internally to evaluate the effectiveness of your mental health program?

Dr. **Nelson**. We have a new set of standards which were issued last year, in March, and we visit service units in every Area once every couple of years, using those standards in reviewing programs within the Areas. We will have covered all the Areas by the end of this year, and we will probably have covered almost all the service units after another go-around, Mr. Chairman. I think that those standards clearly have led to some improvement. We have identified some very serious problems that have been able to be corrected, including keeping Indian persons who are mentally ill in jail for days at a time, instead of sending them to appropriate facilities, and those kinds of situations that we have identified that we have worked with the IHS or tribal communities to correct.

Senator **Daschle**. Does the IHS have a manual which stipulates staff responsibilities?

Dr. **Nelson**. Yes; that is part of the standards as well. I'll be glad to send a copy of the standards to you for the record, if you would like.

Senator **Daschle**. How has this manual been comprised? Has it been updated and evaluated from time to time?

Dr. **Nelson**. It's in the process of being updated. We had a meeting a couple of months ago which included Area personnel and also some of the programs that were evaluated to talk about some of the problems with the review process and the manual; the manual is in the process of being updated right at this moment.

Senator **Daschle**. What steps would you recommend that IHS take with the tribes to work in closer concert in addressing these issues?

Dr. **Nelson**. I think there are a number of issues with regard to tribes that we've encountered. There's a tremendous amount of education that is still needed, in spite of the fact that the programs have been transferred under 638, in terms of what constitutes a mental health program and what kinds of individuals are necessary to provide an adequate program. And it is clear that some of the tribes do not understand what's involved and have had a great deal of difficulty in implementing those programs in a responsible way.

In some instances, it's an issue of recognizing what kinds of individuals are necessary, and in some instances, it is difficulty in getting the salary levels in isolated Areas up to the level where they can recruit somebody who will be a quality kind of person to provide service.

So there is a number of different kinds of issues, depending on the tribe and its location. But we are aware of those and we are available to provide that technical assistance when it is asked for.

Senator **Daschle**. Does it have to be asked for?

Dr. **Nelson**. When we go out and review a program, if it's a 638 program, we may strongly suggest. In terms of tribal sovereignty, we feel that it has to be asked for, unless there's a crisis; if there's a crisis, then we are advised as to what kind of action we can and need to take within the bounds of tribal sovereignty.

Senator **Daschle**. It just seems to me—going back to the incredible severity of the problem, that when you get $13 million, 12 percent of which, probably $1.3 million at least, is used in administration, and you've got 23 beds, how in the world you even begin to address the problem with that limited a budget boggles my mind. How you can ensure, in a process of analyzing how best to use those dollars, what States can do, what tribes can do, how effective your program, are so critical, and I would hope there would be a way you could convince the committee that you're maximizing the impact of those dollars and that, obviously, you're not very content with the limited resources you have.

Dr. **Nelson**. I agree that it doesn't go as far as we would probably like, in terms of providing services. I do think that we are taking some steps to try to maximize those dollars, and I think we are also attempting to work more closely with other agencies who can help; for example, the Rehabilitation Services Administration has some demonstration dollars for vocational training for mentally ill Indian persons that we are trying to tap into, and there are other sources of funds that we are pursuing.

Senator **Daschle**. How about NIMH? What can you do with them? How much assistance can they be?

Dr. **Nelson**. Well, NIMH has been very helpful up to this point. The Research Center that Delores mentioned has been very helpful to us in terms of directing our attention to specific problems through their research. I have talked with Dr. Lourie, who is the head of the Child and Adolescent program, about our providing some more technical assistance to States that have not, for example, applied for a Child and Adolescent Service System Program Grant, and there are some Indian States that have not done so.

Senator **Daschle**. Can you give us some appreciation of the estimated percentage of contracts, health care dollars, that are now being used to address the mental health-related sciences?

Dr. **Nelson**. I don't know that specifically. I would be glad to look that up for you and give you as precise an estimate as I can, Mr. Chairman.

Senator **Daschle**. Off the cuff, any kind of ball park figure?

Dr. **Nelson**. I would hesitate to give you a ball park figure. I would be glad to look it up and provide it for you.

[Material submitted follows:]

CONTRACT CARE COSTS FOR INPATIENT MENTAL HEALTH CARE BY HOSPITAL TYPE AND DIAGNOSTIC CATEGORIES FISCAL YEAR 1987

ICD9–CM	Discharges	Days	Cost
All hospitals:			
290	6	51	$7,658.59
293–303	385	4,113	825,188.51

CONTRACT CARE COSTS FOR INPATIENT MENTAL HEALTH CARE BY HOSPITAL TYPE AND DIAGNOSTIC CATEGORIES FISCAL YEAR 1987—Continued

ICD9–CM	Discharges	Days	Cost
306–316	205	2,912	470,651.79
Total all hospital	596	7,076	1,303,498.89
GMS hospitals (01):			
290	6	51	7,658.59
293–303	308	2,275	624,616.82
306–316	149	1,395	322,660.85
Total 01 hospital	463	3,721	954,936.26
Neuro-psychiatric hospitals (03):			
290			
293–303	77	1,838	200,571.69
306–316	53	1,441	136,555.14
Total 03 hospital	130	3,279	337,126.83
Other hospitals (04):			
290			
293–303			
306–316	3	76	11,435.80
Total 04 hospital	3	76	11,435.80

Source: On-request-report No. 19, dated: June 30, 1988, MHPA&R: July 29, 1988.

CONTRACT CARE COSTS FOR OUTPATIENT MENTAL HEALTH CARE BY DIAGNOSTIC CATEGORIES FISCAL YEAR 1987

ICD9–CM	Contacts	Cost
290	30	$1,980
293–302	1,147	75,702
306–316	1,180	77,880
Total	2,357	155,562

Note.—The outpatient medicare billing cost was used to convert workload to dollar cost.

Source: CHS report No. 3A, dated: June 24, 1988, MHPA&R: July 29, 1988.

Senator DASCHLE. What do you think the estimated backlog of mental health service needs is?

Dr. NELSON. Our estimates, in preparing our National Mental Health Plan, are that we're probably meeting a little bit less than half of the needs.

Senator DASCHLE. You're meeting half the needs?

Dr. NELSON. A little less than half.

Senator DASCHLE. A little less than half? More than 40 percent?

Dr. NELSON. That's our best estimate, based on extrapolations from other studies and the information that we have.

Senator DASCHLE. If we doubled the number of hospital beds, in other words, and if we doubled the budget from $13 to $26 million, do you think we could meet the needs adequately of the entire Indian population?

Dr. NELSON. I think we would come much closer. The 23 beds figure is perhaps misleading in the sense that we do purchase inpatient services from hospitals and we do use State mental hospitals. So we do, in fact, utilize a considerable number of beds more than 23, even though there only 23 that are operated directly by IHS.

I think, to answer your question, that if the budget were doubled, we would certainly come a lot closer to meeting the need, yes. Whether we would meet all the need, I can't say for certain.

Senator DASCHLE. You would be satisfied if all we did was double it?

Dr. NELSON. If the budget were doubled, I'm not sure that our system could gear up with many more funds than that, given our status of development.

Senator DASCHLE. What would you do if you had twice the money? Where would you put the money?

Dr. NELSON. If we had additional funds, I would probably first put the money into children and family services, in the field, community-based. Second, I would probably shore up our adult mental health service system, which is very much overburdened. Third, I would establish some programs for seriously mentally ill people, like day programs, for example. Fourth, I would expand the capacity of our Areas to provide consultation and technical assistance on critical issues like suicide and violence. And fifth, I think that we need some increased training of individuals in certain key areas, because there are some kinds of clinical issues that people have more difficulty in dealing with, particularly in isolated circumstances.

So off the top of my head, that's how I would——

Senator DASCHLE. That's a good answer.

Dr. NELSON [continuing]. Think about putting together a doubling of the budget.

Senator DASCHLE. I've got a lot to learn, I guess, about the whole budgeting process, but it just seems to me that $200 million wouldn't be adequate to meet the incredible needs that we've got out there, if you're talking facilities and addressing the broad range of problems we have. But it's encouraging for someone in your position to tell us that you actually believe you are meeting 40 percent or more of the needs of Indian health. I am troubled by that answer, but if that's your answer, we'll accept it.

There have been reports from time to time that non-Indian people in mental health professions are not very sensitive to Indian needs, Indian problems in particular. There are also reports that Indian Health Service isn't doing all that it can to recruit Indian professionals in addressing many of these problems.

Could you address both criticisms?

Dr. NELSON. I am sure that we could be doing more. We are aware that some of the non-Indian professionals in the mental health area, as well as in the general health area, do not have as much sensitivity or as much understanding as they need or perhaps even a sufficient orientation to Indian country. That that is something that we're working on. Obviously, there are issues around translating language and cultures, when you have two disparate cultures. I think one of the innovative techniques that has been used in the mental health program is to hire what we call mental health technicians, who are individuals from the local tribes who are trained specifically in mental health techniques, and who help to make a bridge between the non-Indian mental health specialists and the community. I think that that bridge has been very effective, and maybe Dr. Zonnis and others might want to comment on how it works.

But it is not perfect, and I think we can do a better job in orienting our people, and I think that that's one of the things I would like to see more of, at least in the mental health program.

Senator DASCHLE. What are you doing in it? I mean, obviously there's a desire there, but what are we doing to put that desire into effect?

Dr. NELSON. Well, one of the things that we have planned is to have joint meetings where we're addressing these kinds of issues, the cross-cultural sharing. I know some of the Areas hold those meetings now. There was just recently a meeting on child mental health in the Navajo Area, where I think there was a good deal of sharing of the cultural aspects of child rearing on the Navajo Reservation, combined with the professional expertise of some child mental health professionals; and there was a lot of sharing of, how the professional approach needed to be modified to be effective with the Navajo community, for example.

I think more of that kind of thing is necessary, really, on both sides, for Indian people and for the non-Indian mental health professionals.

With regard to recruitment, I do feel very strongly that we need to recruit Indian professionals. We have strongly supported the inclusion of psychology in our 437 scholarship program for Indian psychologists, and we look a lot longer and a lot harder for Indian candidates. We are just hiring our national social worker to head up social services for our program, and we recruited that position three times until we could identify an Indian candidate who was appropriate for that job.

So I am very committed to that. Again, it's a difficult thing. There are only 12 Indian psychiatrists. And so we have to be competitive.

Senator DASCHLE. We talked about interfacing with both States and tribes. Dr. Vanderwagen, what consultation is utilized with regard to plans developed with the tribes in implementing Indian mental health policies and plans within the reservation? Do you have a format? Do you have some kind of a specific implementation program that you utilize from one reservation to the next?

Dr. VANDERWAGEN. Well, certainly, a format that we use fairly consistently is one that we can't claim any credit for developing. This is one that comes from the Centers for Disease Control, and I think was first described by Marshall Krueter, and Larry Green. Marshall works down there, and Larry Green used to work down there. He was with the President's staff when President Carter was in office. And it's the planned approach to community health, and by utilizing a planned approach to community health format, work with the communities to identify what issues do the communities see as important, what strengths and resources re available to address that, and then prioritizing together what we can do in using those resources most effectively to address the issues in a priority format to the extent that we can.

There is a very successful application of that, the Cheyenne River Reservation. There have been multiple other applications of that type of approach to planning, certainly, community mental health, but other aspects of health programming as well. And we feel that that has tremendous promise for formalizing, institutionalizing, and providing a stated and more formal process for working through these problems at the community level.

At the national level, Dr. Nelson didn't highlight this tremendously, but that national plan development process we feel has to undergo the same kind of rigorous review and input, not only from health professionals, but also from community leadership, national tribal leadership, interested individuals, and certainly we circulated that in many different forums, both in a formal and an informal fashion.

Last week there was a major meeting in Green Bay on salvages, and Dr. Nelson spoke there, and in the process, invited comments, commentary on the national mental health plan as it is developing.

So there are formal ways at the community level, formal ways at the national level, but there are a variety of informal processes as well.

Senator **Daschle**. We have a lot of witnesses, and I should excuse this panel, I suppose.

Just one last question, and then I would ask if there are any final comments from the panel members.

Compared to where we were in 1978, arbitrarily ten years past, have we made progress, or have we regressed?

Dr. **Nelson**. Well, I think it depends on how you define "progress." We have added a certain number of staff, and I am not sure I could tell you how many, since 1978, so that our program is larger. On the other hand, there remains considerable turmoil in communities, and I see one of the functions of our program, Mr. Chairman, as trying to assist not only individuals, but also communities as Dr. Vanderwagen said, to take hold of some of these issues and to reestablish some of those values that existed in terms of controlling violence and alcoholism, protecting children, and those kinds of things which are related to mental health. And so I think we are making slow progress, but, all of us would like to see that rate of progress increase.

Senator **Daschle**. Your answer, then, is that, in your view, in ten years we have progressed rather than regressed?

Dr. **Nelson**. I would say we have, slightly.

Senator **Daschle**. Does anybody differ with that point of view?

Dr. **Vanderwagen**. Can I respond to that, Mr. Chairman?

I was going to offer an addendum to Dr. Nelson. I would say there has been tangible progress in community interest, community attitude, community willingness to address this. I think there has been tangible progress on the part of the medical system to recognize and respond to these issues. And in that measure, I think there has been fairly significant progress. In terms of the health status indicators, I am not so convinced that there has been the kind of progress we would like to see at all.

Senator **Daschle**. That gives me a much better appreciation.

I had meant to excuse the panel, and I have a couple of questions that I need to ask for the record of Dr. Parron.

Dr. Parron, what is the representation of Indians and women on the Advisory Board of Alcohol, Drug Abuse, and Mental Health Administration?

Dr. **Parron**. On the Advisory Board for ADAMHA?

Senator **Daschle**. That's right.

Dr. **Parron**. There is not an American Indian on the ADAMHA Advisory Board. If you are talking about initial review committee, I would probably say that we have had probably two, or three at any one time ever the last 4 years.

Senator **Daschle**. Out of how many?

Dr. **Parron**. Out of about 385 total members on ADAMHA Advisory Committees.

We have special situations such as we did recently, when we were reviewing applications for the Minority Research Centers, we made a very special effort to recruit representation from each of the four racial minority groups who were competing for those. We had two American Indians on the initial review group.

Senator **Daschle**. That is unfortunate. Has there ever been a member on the Advisory Board?

Dr. **Parron**. On the National Advisory Committee, I don't know if LaDonna Harris served or not.

Senator **Daschle**. She says no.

Dr. **Parron**. She says no. Okay.

Senator **Daschle**. What mechanism is in place, if any, for NIMH to exchange information regarding its research findings with Indian Health Service? We talked about that a little bit with Dr. Scott.

Dr. **Parron**. We have been involved in an ongoing way in the committee to develop plans for the mental health section of IHS. Scott (Dr. Nelson) is a regular visitor to my office, and my office is a regular participant in activities.

Senator **Daschle**. Would you describe any community-based mental health programs that are supported by NIMH funding?

Dr. **Parron**. In the testimony, I submitted for the record, I listed some of them. In the Child and Adolescent Service System program, we've got activities in Alaska that are emphasizing the Native Alaskan populations and special local native projects in Bethel and in Kotzebue. In Idaho there is the paid volunteer component, that provide services for seriously emotionally disturbed children and adolescents, with an emphasis on recruiting and training American Indians.

In Oklahoma, there is an activity that sponsored a national meeting on the Mental Health Needs of American Indian Children and Adolescents that was co-sponsored with the Indian Health Service. And part of that activity in Oklahoma focuses on children who are at risk for fetal alcohol syndrome.

In Wisconsin, the activity involved two demonstration projects directed toward service systems for children from American Indian tribes in that State.

In New Mexico, there is one with the geriatric population, an activity with Santa Fe and Sandoval Counties and two of the Pueblos, San Felipe and Teseque, and that's an outreach and crisis intervention activity, and educational workshops for American Indian elderly.

Senator **Daschle**. We have a vote, and I suppose I should call the committee into a recess for the moment.

But I again want to reiterate my thanks and that of the committee to the panel for your testimony, for your answers to our questions. I appreciate it very much.

The committee stands in recess.

[Recess.]

Senator **Daschle**. We will resume.

Our second panel of witnesses includes Dr. Marion Zonnis and Ms. Phyllis Old Dog Cross. If the two witnesses could come to the table, we will begin.

We are delighted that you could come this far and share your thoughts with us on this very important issue. In particular, Ms. Old Dog Cross, I am pleased to have a constituent here. If there is anything I can do for you, get some water [laughter]. Carry your luggage to the airport. But let us proceed.

Since you are listed first, Dr. Zonnis, let's proceed with you.

STATEMENT OF MARION ZONNIS, MENTAL HEALTH BRANCH CHIEF, NAVAJO AREA HEALTH SERVICE, WINDOW ROCK, AZ

Ms. **Zonnis**. My position is Director of the Mental Health Branch on the Navajo Reservation. I have been in this capacity or a similar capacity for over 15 years. And I have approached this situation from the point of view of knowing about mental health on the reservation that I work on.

The general statements that were read initially and subsequently, particularly by Dr. Scott Nelson, certainly pertain to Navajo, but I think my best offering is to tell you what we are doing, because we do have a somewhat unique program on the Navajo Reservation.

We are unique in that we are a very large reservation, with some 25,000 square miles of contiguous territory, and we service a population of about 180,000 Navajos. So we are unique in that we primarily work with one tribe. This tribe, just like all the others, is traumatized in many ways because of socioeconomic and sometimes political considerations, and all of these considerations do impact on the mental health of the population as a whole.

I am not going to elaborate on that, but it is a fact to be recognized and considered when we look at the mental health of the people.

What we do is one way of trying to meet the mental health challenges on the reservation. We have a program that consists of 45 positions to 47 positions that is funded out of the National Mental Health budget as a line item.

I might say that I could easily double or triple this number of positions and put people to work immediately. There is no problem there.

We have a recurring budget of over $1,700,000. Our personnel are scattered in eight service units, with 6 hospitals, three in Arizona, and three in New Mexico. We also have mental health personnel all in the form of mental health clinics, at three major health stations, and part-time clinics at outlying major health centers.

In addition to our outlying clinics, we have a 13-bed inpatient ward at Gallup, as was previously mentioned. This ward now invariably has a waiting list, and people often have to wait 2 or 3 months, unless they are crises, and often crises cannot be handled because there are no beds available, and we frequently have to resort to contract care in a neighboring community off reservation.

In Gallup, in addition to the inpatient ward, which is unique on Navajo, we have a child psychiatric team of four persons. Their positions are a child psychiatrist, a child psychologist, a psychiatric social worker, and a secretary. This team has been in existence now for about three years. At first they were received somewhat indifferently as an intrusion. At this time, all of our service units are asking for child psychiatric teams for themselves. Our problems with children have been already mentioned, and this team has been effective but limited in the scope of its ability to handle all of the problems that are presented. So children's services loom largely as in need on our reservation.

The program is multidisciplinary. We have the various mental health disciplines, but do not have enough positions to have complete interdisciplinary teams at every service unit, so we have roughly defined four regions, because it is such a large reservation, and attempt to have an interdisciplinary team in each region.

Our staffing is somewhat unique in that we have psychiatrists at all of our service units. All of these psychiatrists are members of their medical staff. And over a period of time, the mental health program has gotten closer to the general health system in the various service units and hospitals because of our medical specialists.

Our staff consists of positions for 12 psychiatrists, 5 clinical psychologists, 12 mental health specialists—these would be people on a masters level, and most of them are social workers on a masters level. A couple have masters levels in other disciplines that are related to mental health. We have 10 mental health technicians, and the other positions are secretarial and supportive.

All of our 12 mental health specialists and our 10 mental health technicians are bilingual Navajos. So that is 22 persons who are Navajo in our program.

All of these positions have been developed in an effort to make our programs more professional and more Navajo in terms of composition. So far we do not have any Navajo psychiatrists, but our mental health specialists are all Navajo and Navajo-speaking.

We also have one Ph.D. level psychologist who is present here, who is a Native American of another tribe.

As I indicated, all of our clinical resources are strained. Our people work very hard. They are continually asking for assistance, for more personnel, and type trading where the needs are greatest becomes a real challenge when one has limited funds.

In the past year, the clinical load has consisted of some 30,000 patient visits involving over 12,000 persons. In addition to the clinical activity, our staff participates in many aspects of community mental health either initiating programs or networking with other groups and agencies. For example, in the past year we have produced a video tape on teen depression. We are in the midst of a wilderness therapeutic teen-age week expedition. We are having a psycho-drama workshop this summer. We have had, in one service unit, a spiritual retreat for the entire staff. One of our service units has produced a detailed catalogue of all human services in that service unit. And some of our service units, our personnel are spearheading finding battered women shelter facilities. We participate in the various child protection teams, in alcoholism programs, in parenting training, parenting classes, in jail clinics, and numerous other activities. Some of these are done solely by our staff members. Some are done with members of the community and members of other agencies.

Part of our effectiveness we see has to be through networking and, as more resources are planned by the Navajo Tribe, many of our professional people are involved in training other service deliverers in mental health matters.

We suffer, of course, as I said, from all of the ills that have to do with poverty, poor roads, lack of education for many of the people. We know that the children lag in the grades beginning at about the 3rd grade, they begin to fall behind. It calls for psychoeducational approaches that must be developed to bring our children up to educational parity. We know the dropout rates in high school are high, that substance abuse is a severe problem, that teen-age pregnancy presents many problems, and that many of these problems tend to not only cause the person who has them to suffer, but it is a suffering that is passed from generation to generation, and sometimes from one family member to the other.

Senator **DASCHLE**. Please summarize your testimony at this point, Ms. Zonnis.

Ms. **ZONNIS**. Yes.

Senator **DASCHLE**. As impressive as it is, I have a lot of witnesses that I have got to hear yet today. So I appreciate it. Thank you.

Ms. **ZONNIS**. OK. I just want to mention that there are strengths, however, that we try to take advantage of. The traditional family and clan ties are a source of strength to many people, and traditional healers, I am sure, help many people. This is an unknown number, but by personal testimony we know that this is an asset on the reservation.

If you want me to stop now, I will stop, but I have more to say.

Senator **DASCHLE**. Let me, I will certainly ensure that the entire statement will be a part of the record, and the information you have provided the committee is immensely helpful. I know I speak for the whole committee in expressing our gratitude in that regard.

Senator **DASCHLE**. Let me ask now Ms. Old Dog Cross if she could proceed with her testimony and enlighten us from a South Dakota perspective.

STATEMENT OF PHYLLIS OLD DOG CROSS, PSYCHIATRIC NURSE CONSULTANT, REGIONAL MENTAL HEALTH PROGRAM, PUBLIC HEALTH SERVICE HOSPITAL, RAPID CITY, SD

Ms. **OLD DOG CROSS**. My name is Phyllis Old Dog Cross, and Senator, it is an honor to be present in front of you for your committee.

I am a registered nurse, trained at a masters degree level, and I am a psychiatric nurse-clinician by practice.

I will talk about our program in Rapid City, South Dakota, at the Indian Health Service Hospital there.

Our program was started in 1978 as a result of Public Law 437, and in starting it, we planned and organized and started on a comprehensive community mental health center kind of philosophy, to contain all five components for service delivery, and have pretty much been able to keep those five components, in spite of lots of problems with staffing and funding.

We serve the reservations of North Dakota, South Dakota, Minnesota, Wisconsin, Nebraska, Iowa, Montana, and Wyoming. Our patient load comes from all of these States, and even come from as far as California, Washington State, and the East Coast.

Since 1982, when we officially opened our doors, we have served 1,100 inpatients. I will talk about our inpatient component. We have nine beds, and will be speaking of a nine-bed inpatient unit. One-half of in-patient referrals come from Pine Ridge, and 25 percent of the referrals come from Rapid City. All the rest of the referrals come from the other States that I named.

Of the diagnostic categories that we treat in our inpatient unit, 45 percent have a diagnosis of psychosis of various kinds. 18 percent are personality disorders, 28 percent are affective disorders, and 9 percent are other types of disorders.

Many of our patients frequently have problems with substance abuse, alcohol, sniffing, other drug usage, and very frequently have problems of violence to themselves or within their family. For instance, of the women that have been admitted to our program, almost 90 percent of them have been sexually abused as children. That's a remarkable number.

We have an 81-percent bed occupancy rate, which people who keep track of those things tell me is a very high rate. And we always have a waiting list for our services.

Our average length of stay is 17 days. About one-third of our staff time is spent on our inpatient unit. The rest of the time is spent on our other components of service delivery. We provide consultation to reservations; for instance, my specialty is consultation with battered women and sexually abused children.

We see approximately 250 outpatients a month in our service, and many times that includes a family, and a family is counted as one. We provide emergency 24-hour care and treatment, meaning that any Indian person can receive psychiatric care at any time at our facility, both our outpatient and inpatient if we have beds available.

I think, in talking about needs, everybody I suspect that presents is going to discuss needs, and I would like to discuss the needs of the chronically mentally ill.

In the reservations we serve there is a very high number of chronically mentally ill patients, and many of them suffer the same problems that any chronically mentally ill do in any place in the United States. Many are homeless or rejected by their families, and many are suffering from what we call dual syndrome, alcohol and drug abuse with mental illness.

I see a great need for attention to this particular group, because they get left out all the time in any kind of mental health services.

People tend to look for emergent situations and we tend to neglect the chronically mentally ill.

The other area I think that needs a great deal of attention is family violence, and in this category I am going to include the adolescents and children. Our children and our adolescents see on a daily basis, incredible violence within the families. One Indian woman I was talking to from a local reservation said that most Indian women on that reservation, at least 50 percent, have been sexually abused as children. And if a child is sexually abused, that scars them for life and they suffer from that as adults.

All the abuse, including battery of women, homicide, battery of children, sexual abuse, is an exploding problem on American Indian reservations.

I would especially like to ask the committee to pay attention to child sexual abuse which is increasing on reservations. It is frequently connected with alcoholism.

I think my one suggestion is that I think we should look more to family approaches in model treatment, rather than individual approach. I think we need to start looking at the family and developing family methods of treatment, because whenever a problem occurs it's always within a family, and we need to treat the whole family instead of focusing on the presenting case.

Many of the workers I've worked with in Mental Health Care refer to their services as MASH units; they are treating the emergent, violent, more critical cases, and they feel like they're running MASH units. Sometimes we feel we're providing band-aid services and need to really look more into epidemiology and what's causing this and focus more on prevention.

Thank you. I will answer questions if you wish.

Senator DASCHLE. Thank you, Ms. Old Dog Cross.

For the benefit of those in the room, as well as for the official record, I think it is worth noting that you are the first recipient of the Wonder Woman Award, in national recognition of persons who have contributed to society. And, having just heard your eloquent testimony, I think you are a fitting recipient of the Wonder Woman Award. I don't know if that requires a cape or not. [Laughter.]

I see you don't have it with you this afternoon.

Ms. OLD DOG CROSS. Able to leap off a tall building. [Laughter.]

Senator DASCHLE. I am fascinated by your testimony. The question that comes to mind, having heard what you just provided the committee, is one that I presented to the first panel, and that is, what would it take to more effectively address the problems that you confront on a daily basis? Is it merely a matter of money? Is it a recruitment of additional personnel? Is it reprioritization of funds currently within IHS?

If you could fix it, if you could do some things to make a substantial difference, what would be the first and second priorities with regard to accomplishing that task?

Dr. Zonnis.

Dr. ZONNIS. I have to say more positions.

Senator DASCHLE. More positions?

Dr. ZONNIS. Yes. And possibly more money per position, in order to get quality, well-trained personnel.

Senator **Daschle**. You need more people?

Dr. **Zonnis**. More people, primarily. Our people really work very, very hard, and very effectively, I think. But we just don't have enough.

Senator **Daschle**. Ms. Old Dog Cross.

Ms. **Old Dog Cross**. Well, I guess it's kind of all of the above, more money, more staff, more trainees. But I think, philosophically, I would like to see, somehow—I don't know if I can articulate this well enough—a better thinking through of what's happening to us Indians. I mean, why are we suddenly becoming so violent, and why is alcoholism increasing, and why are Indians hurting their children, and why are 14-year-olds having babies? And I think we need to start to take a look, and I'm not sure how do we do it. Maybe through think tanks, or do we get people that are in the field to start talking. I think it has something to do with the tribal leadership, but also professional leadership, people that are in the field. Because a lot of professionals burn out, and we become very disillusioned. And so, I think it is time to start asking a lot of questions of why this is happening.

And Dr. Emery Johnson used to say that we can't just put a paper sack full of money on a tree stump and leave it sitting there. You know, we need to see what's working, and maybe not focusing so much just on the individual child or individual adolescent that is having trouble, but taking a look now at the whole family and the whole community. You know, we have communities that have problems. I will not name them here, but in South Dakota.

But what is it about this community is causing this violence to occur in here, or what is about this family, why is this family succeeding and doing well, and why is this family not?

I think more research in epidemiology as well as treatment.

Senator **Daschle**. A good answer.

Let me just ask you one other question that I asked the first panel.

In terms of progress or regress, what perspective can you give? Are we progressing? Can you look back in the last ten years with some satisfaction, or do you look upon the last ten years and look to the next 10 with some despair?

Dr. **Zonnis**. Satisfaction, and hope, and anticipation, all.

Senator **Daschle**. Satisfaction, hope, and anticipation.

Ms. Old Dog Cross.

Ms. **Old Dog Cross**. I think in terms of positive. The Indian people we work with are all wanting very much this thing called mental health. They are wanting to have better lives. They are wanting to find some way. They are very accepting and very desirous of sensitive treatment or sensitive people, professionals to see. So it isn't that they're rejecting it. They see it as an answer. Some think even too much, you know, that we should have the answers to everything. But I think we are seeing the severity increase. We are seeing more violence, we are seeing more harm to children, we are seeing more alcoholism within families.

I think that would be my answer.

Senator **Daschle**. In both cases, do I take it as your one-word answer that we have progressed?

Dr. **Zonnis**. I think we have progressed.

Senator **Daschle**. Ms. Old Dog Cross, you are hesitating.

Ms. **Old Dog Cross**. It depends on what you're measuring, I think. We have progressed in some areas, but in other areas we certainly seem to be going down the tubes, I know I'm hesitating.

Senator **Daschle**. No, no.

Ms. **Old Dog Cross**. I don't want to say across the board that we progressed, because I think of the areas where we have not, especially in alcoholism, and drug abuse, and family violence.

Senator **Daschle**. Well, I want to thank you both. You have come a long way, and you have done the committee a real service with the testimony you have provided. I want to thank you.

Our third panel is comprised of two people, Ms. Denise Dougherty, the Analyst for the Health Program of the Office of Technology Assessment, and Dr. Stephen Somers, Senior Program Officer of The Robert Wood Johnson Foundation.

Ms. Dougherty, we are pleased you could join us this afternoon.

Ms. **Dougherty**. Thank you.

Senator **Daschle**. Dr. Somers, we are delighted you are here as well.

I invite you to proceed as you see fit. If you could summarize your formal remarks, in order for us to have a discussion, I would appreciate that, and we will call on you, Ms. Dougherty, first.

STATEMENT OF DENISE DOUGHERTY, ANALYST, HEALTH PROGRAM, OFFICE OF TECHNOLOGY ASSESSMENT, WASHINGTON, DC

Ms. **Dougherty**. Thank you. I am pleased to appear before you to present testimony to the committee on issues of mental health.

Mr. Chairman, the Congressional Office of Technology Assessment has completed two reports relevant to this topic. The first was "Indian Health Care," completed in April 1986, and the second was the background paper, "Children's Mental Health: Problems and Services."

We are also just beginning a study of adolescent health, and the Congressional request letter for that study asked that we specifically address the needs of American Indian and Alaska Native adolescents. So we will be looking at that in the future.

Most of my remarks are based on the studies we've already done, and, as you have said before, the existence of mental health problems can be inferred from the incidence and prevalence in a population of the social or behavioral causes of deaths, such as accidents, homicide, suicide, and deaths due to substance abuse. These causes of death are very prevalent among Indians, much more those than in the general population. And what is more disturbing about these causes of death is their prevalence among younger Indians. As with the U.S. population in general, the leading causes of death among Indian adolescents and young people age 15 to 24 are accidents, suicides, and homicides. But the death rates for these causes among Indian youth far exceed the rates in the population at large. I have submitted testimony with figures on those rates.

For example, Indians 15 to 24 have the highest suicide rate of all Indian age groups, while among the general population, the suicide rate generally increases with age.

Similarly, Indians die much younger from alcohol-related liver disease than do the population at large.

The extent of teen-age pregnancy in a population may also be an indicator of the need for mental health and social services. In 1980, 25 percent of Indian births were to girls 19 and younger, compared to a teen-age pregnancy rate of 15 percent for the U.S. population at large.

There are some small area studies of mental health needs among Indian youths and Indians in general. But as the Indian investigator LaFromboise has recently pointed out, only a very few community-wide American Indian epidemiological studies of psychopathology exist. Many of these studies are dated, as well.

As witnesses have already discussed, mental health problems are not surprising, given the poor living conditions of most Indians. The poverty rate is twice that among the general population. Among Indians living on reservations, 44 percent lived below the poverty line in 1979. Single parent families are more likely to be living in poverty as well as to have other stressful conditions, and in 1980, approximately 22 percent of American Indian and Alaska Native families were maintained by women, compared to a rate of 14 percent for the U.S. all races population.

Turning to our study of children's mental health, that study was done primarily to learn the extent to which the mental health field has reached a consensus on the appropriate treatments and treatment settings for responding to our nation's children's mental health needs.

We found that a comprehensive system of mental health services would include, at least: preventive services; a full range of treatment services; case management and advocacy for children; services that are community-based; services to families as well as those directed to individual children and adolescents; services that are coordinated across the mental health, general health, social services, educational, and juvenile justice systems.

We found in that study, though, that most children in need do not receive the full range of necessary and appropriate services to treat their mental health problems effectively.

We can't report to you at this time whether those conclusions we drew about the mental health needs of the nation's children apply to American Indians and Alaska Natives. We will be doing a special report as part of our adolescent health study at the request of this committee, which will address the justification for a comprehensive mental health services system for American Indians, and we plan to deliver a report to you in February of 1989 on that topic.

[Prepared statement of Ms. Dougherty appears in appendix.]

Senator DASCHLE. Thank you, Ms. Dougherty.

Dr. Somers.

STATEMENT OF STEPHEN A. SOMERS, SENIOR PROGRAM OFFICER, THE ROBERT WOOD JOHNSON FOUNDATION, PRINCETON, NJ

Mr. SOMERS. Thank you, Mr. Chairman, for inviting The Robert Wood Johnson Foundation to testify on its programs in Indian health and mental health. We welcome the opportunity to participate in your consideration of possible community-based mental health initiatives for Native Americans.

I would like at this point to ask that my written testimony be included in the record.

Senator **Daschle**. Without objection.

Mr. **Somers**. Thank you. I am here on behalf of the Foundation's President, Dr. Leighton Cluff, and my fellow program officer, Ms. Annie Lee Shuster, both of whom are determined to find appropriate ways for us to contribute in this area.

Before describing some of the programs we are involved in, I would like to say a few words about The Robert Wood Johnson Foundation. It is a health care philanthropy. Its primary emphasis is on developing new and better ways of delivering health services, particularly to vulnerable populations, chronically ill people, babies born of teenage mothers, et cetera. Most of our money is spent on service demonstration programs, although some is also spent on research and training.

We have spent $850 million since 1972, and we are now spending roughly $100 million per year. But to put this in perspective, as our Chairman Robert Myers, has done in our annual report, that is one-tenth of what the country spends on aspirin per year. So our $100 million really does not amount to much in the face of a $400 billion or $450 billion health care bill in this country. Our relatively limited resources require us to invest in developing innovative models that will advance a field as opposed to just supporting routine services for specific populations.

Up until the early 1980's, our rationale was often to develop programs, evaluate them, and if successful, hope that the Federal Government or other public sector agencies would be in a position to disseminate the idea. This scenario is no longer possible. Today we have to focus more on finding the gaps that deserve to be addressed, leveraging other private dollars, and helping people design programs that they can sustain themselves.

I would like to spend a few minutes describing just two national programs that I am personally responsible for at the Foundation which have an impact on urban Indian health and mental health. One of the programs, the Health Care for the Homeless Program, is a 19-city effort to establish primary care for homeless people. Ironically, this is one of our efforts that has been adopted by the Federal Government through the Stewart B. McKinney Homeless Assistance Act. Title VI is Health Care for the Homeless. In three of our sites there are substantial Indian populations being served: in Seattle, the project is working with the Indian Health Board, Albuquerque has mental health and alcohol counseling, for a significant number of Indians, and Phoenix has similar services.

The other program that I would like to mention briefly is the Program for the Chronically Mentally Ill, which is a nine-city effort to improve community-wide systems of care for the mentally ill. Two of our sites have significant urban Indian populations, Denver and Honolulu. In both of those sites, a special aspect of their efforts is that they are recognizing the need for developing culturally sensitive mental health programming for Native Americans, and in Hawaii, for Native Hawaiians.

The Hawaiian Project Director, Ms. Alma Takata, mentioned that it is difficult for public mental health systems to be very responsive to the special needs of native populations. My written testimony describes some of the efforts in Waianae on the Island of Oahu, under our program.

A third national program of some relevance is a $20 million initiative for States and localities to improve services and service integration for seriously emotionally disturbed children and adolescents. The Request for Proposal announcement will be out shortly. It is not specifically for Indian populations, but I do think that there may be overlaps, given some of the previous testimony.

The Foundation has been struggling for over ten years to address Indian health issues directly. Our approach of looking for single models may not work given the heterogeneity among Native Americans.

We, may finally be on the verge of announcing a new program. It is now being considered by the Board of the Foundation. Before I describe it, I would just like to mention a few other programs that we are supporting right now. One in Alaska is to train rural community nurses to provide mental health care where a very small grant, in this case roughly $50,000 can have wide impact. We are also working with the Kaiser Foundation on a substance abuse prevention project with Shoshone adolescents in Lander, Wyoming.

The new program that is under consideration by the Board of Trustees at this time is a $6 million program to encourage Native Americans themselves to design models to deal with the high rates of damaging health behaviors that have led to terrible mortality and morbidity rates. We are going to encourage Indian groups themselves to identify models and to develop new ones for improving health outcomes among their population.

We spoke to the National Center on American Indian Mental Health Research, and found that there is little reliable data on mental health disability among Native Americans. Given the illness and substance abuse rates that have been mentioned already today, we assume that there is some connection to depression and other chronic mental disabilities.

Should it be approved by the Board, this program would give us an opportunity to support efforts to improve community-based mental health services for Indian populations.

We appreciate very much the committee's invitation to participate in its early consideration of community-based mental health initiatives and would like to work with you in the future.

Thank you.

[Prepared statement of Dr. Somers appears in appendix.]

Senator DASCHLE. Thank you, Dr. Somers, and Ms. Dougherty. We appreciate your testimony.

I have no questions at this time, but we may have some for the record that we will submit at a later date.

We thank you both for your testimony today.

Our fourth panel is Dr. Diane Willis, Dr. Jim Thompson, Dr. Linda Cross, and Dr. Steve Silver.

Dr. Willis is the Director of Psychological Services for the Child Study Center, University of Oklahoma. Dr. Thompson is a member of the Association of American Indian Physicians. Dr. Cross is the

Chair of the Subcommittee on Indian Affairs, American Psychiatric Association. And Dr. Silver is a consultant with the Veterans' Administration Advisory Committee on Native American Veterans.

We are pleased to have the four of you before the committee at this time.

Dr. Willis, let us begin with you.

STATEMENT OF DIANE J. WILLIS, DIRECTOR, PSYCHOLOGICAL SERVICES, CHILD STUDY CENTER, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF OKLAHOMA, OKLAHOMA CITY, OK

Ms. **Willis**. Thank you for permitting us to speak before this Senate Committee. We appreciate your commitment to addressing the issues of mental health for the American Indian and Alaska Native children.

I am Diane Willis, Director of Psychological Services at Child Study Center in Oklahoma City. Today, I speak on behalf of the American Psychological Association. I am of Kiowa descent, and my practice at the Medical Center in Oklahoma, includes assessment and/or treatment of children and families, with specific focus in the area of child abuse.

It is traditional in affluent society, to gear one's psychological practice toward the middle and upper class white populations, but the group in greatest need of mental health services is the American Indian, and statistics, which Mr. Daschle reported in his opening statement, have borne this out. This is the minority who dies younger than all other races, is discriminated against out of proportion to other races, holds the highest unemployment rate in the United States, and kills themselves at a rate four times that of the general United States population.

The suicide rate for school-age Indian children alone is three times greater than that of the American white majority.

The American Indian is also the group that dies from accidents, as we heard today, due to neglect or alcoholism, at a rate that is 132 percent greater than the general population in the United States, who dies from homicide at a 73 percent greater rate, and suffers from alcoholism at a rate that is 384 percent greater than the general population.

The American Indian needs mental health services, and we need to deemphasize the medicalization of these problems while recognizing that alcoholism, for example, does indeed create medical problems.

Why do these mental health problems exist among our Indian population? There are a variety of reasons. I will only list a few: Poverty, for example, and economic instability that exists within the reservations adds enormously to the health/mental health problems. A lack of good role models, i.e. fathers who are employed and free of alcohol/drug problems, and parents who are committed to good child rearing techniques.

Poor parenting skills and considerable neglect and abuse that does exist on reservations and in the urban areas add to mental health problems.

Educational failure, leading to poor self-esteem and a feeling of failure contributes to personal problems. This morning some of the groups talked about depression being a major problem among American Indians. When you fail at school and you have poor parents who are unemployed and/or alcoholic and you have experienced a tremendous amount of neglect, it is little wonder that we have Indian children growing up as depressed adults.

There is the lack of adequate mental health services accessible to the American Indian and this is another reason why we have these problems.

And the most important of all is the insufficient reinforcement of the child abuse law that we do have under the Indian Child Welfare Act. And I can tell you that's an important law that is not being reinforced in the way it needs to be reinforced on the reservations, and the Indian people that I have worked with and my own people will say that they are terribly frustrated dealing with the Indian Child Welfare system, because it is not working as effectively as it needs to work. Somehow we need to put teeth into the child abuse law.

What are some of the recommendations that could come out of these hearings?

First, in existing community and mental health centers located in areas of large Indian populations, it seems to me that we could designate at least two or three positions to Indian providers with degrees in clinical or counseling psychology. And second—and within this, provide challenge grants to centers to target services to the American Indian. To carry out the above more monies would need to be appropriated to mental health.

Second, would be to tighten up the Indian Child Welfare Act and let the tribes know that the government is serious about preventing child abuse and protecting children.

Child abuse, and particularly neglect, and the areas of sexual abuse that have been mentioned, is the most destructive and insidious killer of the spirit of young Indian children that exists, and this leads to many of the psychological problems cited by the first panel.

A third recommendation would be to initiate and provide support for prevention curricula in the schools, parenting education courses for the tribes, and provide money for good affordable day care.

As a fifth recommendation, within the Indian Health Service, we need to target more mental health positions, especially child mental health, so that psychologists and psychiatrists will be hired to provide services to children and their families.

A sixth recommendation would be to improve educational standards and provide scholarships at the masters and doctoral level for training in the area of mental health. As one panelist mentioned, they are training and have trained for many years mental health technicians, (this may be a tribal chief's cousin, or someone without a degree), but they are trained in mental health by way of workshops and they do a pretty good job, but they do not have nearly the level of training that is needed for the kinds of problems that are seen among the American Indians. What one could do is to provide preceptorship money for existing mental health technicians, and incentive money at training sites, so that these mental health technicians can receive additional supervised training under doctoral level mental health specialists. And, of course, the training site must meet certain qualifications.

And finally, we must encourage the Indian Health Service to continue to promote, indeed, to take a leadership role in psychologists prescribing psychotropic medication as they currently do.

Thank you for letting me speak today on behalf of the American Psychological Association.

[Prepared statement of Ms. Willis appears in appendix.]

Senator DASCHLE. Thank you, Dr. Willis.

Dr. Thompson.

STATEMENT OF JAMES W. THOMPSON, M.D., MEMBER, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS, ELLICOTT CITY, MD

Dr. THOMPSON. Thank you, Mr. Chairman.

I am speaking for the Association of American Indian Physicians, AAIP, of which I am a long-term member. The AAIP is a professional medical society made up of physicians who are American Indian or Alaska Native.

I will briefly summarize my remarks today in the interest of time, and ask that my full remarks be submitted for the record.

Senator DASCHLE. Without objection.

Dr. THOMPSON. As a psychiatrist with subspecialty training in community mental health, I am aware that over the years the meaning of "community based care" has diverged from its original conceptualization, so first I would like to offer some definitions. Increasingly, over the last decade, community based mental health care has come to mean to many only outpatient care, or at best, non-hospital care.

The AAIP would like to draw the committee's attention towards an understanding of "community based", as comprehensive care, delivered in settings as close to the patient's home community as possible. Comprehensive care includes not only outpatient care, but also a broad range of services including inpatient, outpatient care, psychosocial rehabilitation, day treatment, residential treatment, and other forms of care.

Related to this, the definition of "mental health care" has also changed over the years. The CMHC movement gradually defined mental health care away from the treatment of the mentally ill to provision of counseling for the worried well, a very brief follow-up for previously hospitalized persons, and educational programs intended to prevent mental illness.

The AAIP wishes to present to the committee our understanding of mental health care as the treatment of diagnosable mental disorder, including treatment of alcohol and drug abuse. We do not mean care which is meant only to improve or maintain emotional well-being in an otherwise well person. Improving emotional well-being is a worthy goal, but should not, in our view, take precedence over providing the services needed to treat those with diagnosable mental disorder.

We also believe that the delivery of clinical services must involve extensive face-to-face contact of the patient with practitioners who are highly trained in the treatment of mental disorder. Only with such contact is it possible to deliver the high quality of care for mental disorder which is now feasible. During the last few decades, the ability to effectively treat the mentally disordered patient has grown dramatically. New diagnostic and assessment procedures, effective medications, psychosocial rehabilitation approaches, and targeted forms of psychotherapy are now available. We no longer must rely solely on supportive counseling of persons with mental disorder, as though this is all we have to give. To deny Indian people the benefits of the dramatic progress in psychiatry and mental health related fields amounts to institutional malpractice. There must be renewed efforts to train and recruit high level professionals who can apply the fruits of this progress.

On another topic, we believe that in new and existing programs, the fragmentation of care which is now the norm must be corrected. At present, there are in most Indian communities separate programs for general health, mental health, alcoholism, social services. These often have separate budgets, administrations, staffs, services, and ideologies. The attitude is more often one of competition for patients, rather than of collaboration. This is in the face of mounting evidence of a high co-occurrence of substance abuse with other mental disorders, and between these and general medical disorders and social problems. Anyone who has treated Indian people can attest that these comorbidities are present in perhaps greater amounts than in non-Indians. For no other population is the need to coordinate services more obvious.

There are presently many organizational and political barriers which work against cooperation between general health, alcohol, mental health, and social service programs. We feel that new programs will not be able to accomplish very much unless these barriers are dealt with.

Related to the need for program coordination, is the separation which often exists between tribally run programs, IHS programs, and non-Indian programs which Indian people utilize. Although we strongly support the concept of programs which are locally run by Indian people, ways must be found to encourage such programs to work with other programs, and vice versa. These incentives might be administrative, financial, or political.

We would also argue for an approach to mental health care for Indian people which is built on the needs of the patient, rather than on the ideology of the providers. I have already mentioned some of the mistakes of the Community Mental Health movement. Yet another is the strong tendency of that movement to operate on ideology, rather than on what is best for the individual patient. Any discussion of community based mental health care is bound to be filled with discussions of educational models, social models, medical models, alternative service models, and human service models. Mental healthers spend a great deal of time and energy defining and adhering to their ideological model, so much time and energy that the recipient of services is, in effect, forgotten. What becomes all important is fitting each patient into the ideological framework of the provider, rather than individually assessing and treating each patient.

We therefore hope that any plan formulated by this committee is based on a philosophy which does not rule out any approach which may be of benefit to the recipients of care, and also on an approach which lends itself to evaluation and research to determine its effectiveness.

Finally, we feel that specific attention must be paid to the cultural relevance of services delivered to Indian people. This is a precept which is often stated, but is seldom applied in a systematic way. There are, however, specific steps which might be taken to move toward cultural relevance. We note several of these in our written testimony.

We do believe that cultural relevance can be achieved in approaches which combine western medicine with traditional culture and values, utilizing the best from each tradition.

Mr. Chairman, thank you and your committee for your efforts to address the tremendous unmet health needs of American Indian and Alaska Native people. We stand at AAIP ready to work with you over the next several months in dealing with these difficult issues.

Thank you for allowing us to testify.

[Prepared statement of Dr. Thompson appears in appendix.]

Senator **Daschle**. Thank you, Dr. Thompson.

Dr. Cross.

STATEMENT OF LINDA KAMES CROSS, M.D., CHAIRPERSON, COMMITTEE OF AMERICAN INDIAN AND ALASKA NATIVE PSYCHIATRISTS, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. **Cross**. Mr. Chairman, I am Dr. Linda Kames Cross, Assistant Professor of Psychiatry at Michigan State University, and chair of the Committee of American Indian and Alaska Native Psychiatrists of the American Psychiatric Association, a medical specialty society representing more than 34,000 psychiatrists nationwide.

I want to thank you for inviting me to testify here today, and will try to summarize my written statement.

First, I want to point out that mental health and physical health are quite interrelated. If mental health were properly addressed, the cost of physical problems might go down greatly. For example, you have heard the figures about the increased accident rate, homicide rate, and suicide rate. Think about the people that didn't die in those attempts and ended up having to have medical treatment, as well as the treatment costs for alcoholism, cirrhosis of the liver, and other kinds of physical problems that are symptoms of an underlying depression or other psychological problem.

One very important point that I haven't heard mentioned today is that almost two-thirds of the Indians in the United States live off of the reservation. Over half of our Indian population lives in urban areas, yet most of the money is given to the Indian Health Service and to Indians on reservation. I would support Dr. Nelson's statement that doubling his budget might meet the need on the reservations, but I don't think it would meet the need of the Indians in urban areas and non-reservation rural areas.

We have a few Indian Health Centers in urban areas, but that doesn't begin to meet the need of non-reservation Indians who have equally as many psychological problems as the reservation Indians. The problem tends to be different in that, when Indians are part of a community, alcoholism and other mental health problems can be treated as community problems. When Indians are not part of a community, they have problems because they are socially isolated. I think that one of the things that we need to do is to support our Indian college students, for example, who are so isolated and homesick they often don't make it, or if they do, they make it by becoming totally acculturated and losing their Indian identity. We need to hang onto these people, because we need role models. People who have successfully adapted to our society and yet maintain the sense of identity and pride in their heritage.

Also, during the process of self-determination and growing to become independent I think we need your help in enforcing accountability in Indian-run programs to ensure that nepotism and corruption do not take away what little money we have, and result in it not being given to the people that need it most.

I sympathize with Dr. Vanderwagen's statement about available money having to be used right now to put out fires and treat the people in emergency rooms who obviously need treatment, leaving little much left for prevention. I think when it comes to mental health, we are not going to change this picture at all unless we can do something along the lines of prevention. I would not want to see the money taken from treatment in order to do that, I think we need more money.

You have heard time and again this afternoon about the prevalence of abuse, sexual abuse and physical abuse, and violence. These kind of problems require intensive treatment from a professional and not just a mental health technician. I don't want to undermine what the mental health technicians are doing, I think they are greatly needed, but they should not be expected to deliver care that really should be given by a professional. They could probably benefit from further training in psychiatric diagnosis, and learning when to refer. However, if there is no one to refer to, that can mean more frustration for the technicians. As a result, I also support Dr. Willis' and Dr. Thompson's statements about the need for more Indian professionals and more positions in the Indian Health Service.

My biggest complaint about the administration of treatment programs—one I think something could be done about because it is not just a matter of more money but a matter of reorganizing—is the fragmentation of care between the substance abuse program and the mental health program. It doesn't make sense, professionally or clinically, to keep these programs separate. I know that the programs are separate today because of old rivalries that go back before I was in practice. However, I see what happens when you have two separate programs and one patient with both problems. They are expected to go back and forth, and sometimes the programs become actual rivals rather than cooperative treatments. We need to foster more cooperation between those programs. I think we could combine their budgets and require the administrators to have expertise in both areas. That would really make it much more coordinated.

In the Eastern States, such as Michigan, where I am from, Indian Health Service monies are contracted out and most care is rendered by community mental health centers. These have been vastly underutilized according to the little data we have. There are a couple of reasons that have been cited for that. One is that Indians, or at least some that I talked to, say that they never realized that help was available for depression. They thought depression was a way of life. They thought you had to be crazy to go to a mental health center, you had to be crazy to see a psychiatrist, and that the only people that needed us were those that needed to be locked up.

Education and awareness of the symptoms of depression and what help there is available would go a long way toward addressing the problem.

There are also complaints about the atmosphere in mental health centers, and their insensitivity to Indians' needs. One example of this is the fact that Indians tend to be treated as individuals in one-to-one psychotherapy without much attention paid to their families or to the support systems and resources in the Indian community. It has been recommended by a number of different professionals that we need to have more community involvement, and I will just reiterate that. Another thing we could do would be to have more Indian representation on community mental health boards.

Last, I want to mention a problem that I haven't heard too much about today. The problem of jurisdiction with Indians on reservations in need of civil commitment for reasons of dangerousness to self or others. There is no across-the-board way that this is dealt with. It is taken on a State-by-State basis, or location-by-location basis. Because States are not necessarily mandated to treat Indians—they can choose not to treat, and sometimes these Indians end up in jail or just not receiving treatment—it is a very difficult problem. I don't have any creative solutions, because I don't know much about Indian law, but I think that something on a Federal level could facilitate this problem.

Thank you.

[Prepared statement of Dr. Cross appears in appendix.]

Senator DASCHLE. Thank you, Dr. Cross.

Dr. Silver.

STATEMENT OF STEVEN M. SILVER, CONSULTANT, VETERANS' ADMINISTRATION ADVISORY COMMITTEE ON NATIVE AMERICAN VETERANS, COATESVILLE, PA

Mr. SILVER. Thank you. I am Steven M. Silver. I am a clinical psychologist currently serving as a staff psychologist with the VA Medical Center in Coatesville, Pennsylvania, where I work as the Coordinator of the Observation and Evaluation Unit of the PTSD program. I am also a consultant to the National American Indian Vietnam Veterans Working Group, which reports to the Readjusting Counseling Service of the Veterans Administration.

I submitted my remarks to your clerk here, and if we can have them just taken into the record, I'll try to summarize the results of our survey.

Senator DASCHLE. It will be submitted in full. We will appreciate your summary.

Mr. SILVER. Thank you.

The Readjustment Counseling Service started the American Indian Working Group in 1983. One of the things we became aware of very quickly was that there was a very almost total lack of information about how American Indian Vietnam Veterans and veterans as a whole within the American Indian community were adjusting.

We set out to do our own study. I should point out that this study represents some of the first hard data gathered on this particular population and its reason for being brought here is that it does reflect some of the mental health problems of these particular segments of the American Indian population are having.

We do not know of any other hard study that has been done up to this point. The study was also done more or less out of pocket by the members of the American Indian Working Group, inasmuch as support funds and resources were simply not made available.

Our survey was able to gather data from 170 American Indian veterans from about 60 tribes. Almost all were male. The mean age at the time of responding was 40. Their average age in Vietnam was 19. Of the 170, 147 actually served in Vietnam.

Close to 80 percent of our sample enlisted. Only about 20 percent had to be drafted.

The most common MOS in Vietnam was infantry or rifleman and 64 percent stated that they saw moderate to heavy combat; this self-report is supported by the fact that these 147 individuals won 234 decorations and awards, including 72 Purple Hearts. I suspect, frankly, that they are underrating the amount of combat exposure they actually were involved in.

We saw a high level of volunteerism and a high level of combat, and that led a number of us who have been working in the field of long-term combat reaction to expect that we would see relatively high levels of long-term reaction, such as post-traumatic stress disorder. The survey looked at PTSD, drug and alcohol abuse, and social problems like employment, and so forth, and I will summarize some of those: 81 percent of our sample indicated mild to severe problems with alcohol abuse after Vietnam. Only 42 percent felt they had resolved the problem. Drug abuse was not as high, only 32 percent, though only 34 percent felt they had overcome the problem.

PTSD symptoms were a significant problem. 80 percent of our population experienced mild to severe depression, 76 percent reported sleep disturbances, 64 percent having flashbacks, 71 percent having problems with anger and rage.

It should be pointed out that, because of our lack of funding, these percentages are of the total number responding, all 170. We did not have the money to take it back to the computer and rerun it just for the Vietnam vets. So the percentages should actually be regarded as much higher.

The computer analysis was done by Dr. Tom Holme at the University of Arizona, and the funding for the research was done out of his private research money for his Political Science Department, and we are grateful to him.

A surprising figure that came up was that 64 percent of the veterans reporting these problems had not sought help through the VA Vet Center program. And again, this number is undoubtedly not representative. We believe that it is a gross error, since it was inflated by the distribution of surveys through Vet Center. We gained the cooperation of a number of Vet Centers in passing out these surveys. So there was an overrepresentation. So the initial inclination would be to say that about a third of our folks have gotten some kind of help through the VA. As I say, because of the way the sample was run, that is certainly an exaggeration. It is undoubtedly, in realistic terms and generalized to the whole American Indian Vietnam Veteran population, much worse than that.

A surprising result was the high education level of the participants. The majority, 92 percent, had either graduated from high school or held equivalency degrees, and 61 percent had some college experience. Forty percent reported that they were currently unemployed.

We also examined why they entered the service and the main reason seemed to center around family and tribal tradition.

To summarize the results of the survey, the Working Group found American Indians volunteered in high numbers, served at a disproportionately high rate in combat, came home with the same emotional problems as other Vietnam War veterans, had more cultural and social supports than their non-Indian counterparts, but still had unresolved issues.

We feel that there are still very significant barriers for American Indian veterans in getting services from the VA. These barriers include few facilities in Indian country, and long distances to the few available facilities, distrust of government programs in general, and a lack of Indian people involved in providing the services, as well as a failure by providers to understand the special needs and culture of American Indians.

We therefore support the proposed initiative to establish a comprehensive community-based mental health services program staffed by qualified Indian people. We see it as desperately needed.

We would also like to see, as would the Vietnam Era Veterans Inter-Tribal Association, another more comprehensive survey conducted among American Indians more closely paralleling the recently completed study of Vietnam War veterans conducted by the VA, and from which American Indians as a group were excluded.

The final issue that I would like to briefly mention is on the problem of service provision and training issues. The National Working Group, as an advisory body, has been called on from time to time by the VA to provide identification and input concerning the provision of mental health services by people who have been working within the VA or are contractee providers for the VA.

Over the years several situations were brought to our attention where inappropriate use of so-called Indian ceremonies were used with non-Indian veterans. Also, non-Indians are providing training to VA staff, and this is currently happening, on "culturally appropriate" methods of intervention and treatment of American Indian veterans.

We feel one of the problems about a massive expansion of a community-based mental health system would be a tendency to start plugging in warm bodies to do the work without regard to their abilities and backgrounds and cultural sensitivity. Therefore, it is the strong opinion of the Working Group that only those persons qualified and recognized within the Indian community as legitimate, first, should be conducting any type of traditional ceremony or ritual whether it is for Indian or non-Indian veterans, and, second, should be providing the crosscultural training. The legitimate people are available and there are a number of organizations that can help tie those hopes in.

We believe that any contract services for veterans or others within the Indian community should be conducted through and with the aid of the local Indian agencies such as the tribal governments or the Indian Health Boards. We came up with a proposal for the Readjustment Counseling Service of the VA, a draft of which is available and will be included with my statement for the record.

Finally, just before coming, I received a copy of a letter from the Vietnam Era Veterans Inter-Tribal Association, which is the largest American Indian Veterans organization, requesting that, or supporting our proposal that a larger survey, a National Survey on American Indian Veterans be conducted.

They raised a number of objections to the process as it has currently been conducted by the VA, including the point that I already mentioned, that American Indian Veterans were excluded from the National Study on Vietnam Era Veterans.

And they also point out a number of problems that the VA has had in supporting its own working group on American Indians, including the fact that it was a year later starting this working group as opposed to the ones on Women, Blacks and Hispanics, and within the entire Readjustment Counseling Service, the Vet Center Outreach Program, only six American Indians are currently working there.

They go on to cite a number of other reasons why they would like to see this national study be conducted by someone else, preferably by them, and many of the points that they raise, if not necessarily the conclusion, the Working Group on American Indian Veterans would support.

I thank you.

[Prepared statement of Mr. Silver appears in appendix.]

Senator EVANS [presiding]. Thank you very much.

I have to take over. Senator Daschle had to leave. Unfortunately, I didn't hear the other parts of the testimony, but all of us will be happy to have the testimony presented and use it and its synthesis for trying to get at some very, very difficult problems. I know Senator Inouye has the intention of trying to move ahead with appropriation legislation and looking ahead to the next Congress.

We do thank you for your appearance.

Next is Panel 5, Dr. Marlene Echo Hawk, Clinical Psychologist and Member of the Otoe-Missouria Tribe, of Red Rock, Oklahoma; Mr. Edward Wadda, President, Wind River Reservation Youth Council, Fort Washakie, Wyoming, and Ms. Vivian Juan, Trustee, United National Indian Tribal Youth, Oklahoma City, Oklahoma, accompanied by Mr. J. R. Cook, Executive Director of UNITY.

I think we will start with Ms. Echo Hawk.

STATEMENT OF MARLENE ECHO HAWK, CLINICAL PSYCHOLOGIST AND MEMBER, OTOE-MISSOURIA TRIBE, RED ROCK, OK

Ms. Echo Hawk. Mr. Chairman and members of the Committee. My name is Marlene Echo Hawk. I'm a Clinical Psychologist and a member of the Otoe-Missouria Tribe from Oklahoma. I appreciate the invitation to provide testimony on behalf of my tribe and in my capacity as a mental health professional.

I will keep my statement brief.

The Otoe-Missouria Tribe commends the Select Committee on Indian Affairs for their concerns for the mental and emotional health care needs of American Indian and Alaska Natives.

1988 marks the 25th year since the Community Mental Health Systems Act was passed in 1963. Looking back, we can assess what methods have been found to be most efficacious in the treatment of mental disorder for those utilizing community mental health centers. Reasonably, we can integrate that knowledge with traditional American Indian and Alaska Native healers' approaches to mental health.

What is sometimes considered innovative has really been around a long time. For example, Native Americans, for centuries, have utilized art, song, and dance as well as medicine to help tribal members who are mentally disturbed to respond to their emotions. Over the years we have seen many of our valuable Native American treatment approaches underutilized and even ridiculed, but mostly ignored by those not understanding the full meaning and value of traditional Native American healers. As a Native American clinical psychologist I enthusiastically envision a blending of all we know about the treatment of mental disorders for the total well-being of Native Americans and Alaska Natives.

Over the years the erosion of the Native American And Alaska Natives Cultures has taken its toll. We have heard much of the testimony earlier today itemizing what those problems have been. The physical, mental, and social functioning of Native Americans has been seriously damaged. Like fertile soil that provided abundantly, the erosion process has been set in motion. We are now talking about reversing this process by conserving what is left and eventually restoring fertile ground.

This is an exciting and unique time to consider comprehensive community-based mental health services for Native Americans and Alaska Natives.

The Otoe-Missouria Tribe:

1. Supports the concept of comprehensive community based mental health centers.

2. Acknowledges the need for cultural sensitivity regarding mental health treatment for Native Americans and Alaska Natives.

3. Strongly recommends the integration of traditional medicine people into the comprehensive community based mental health centers.

4. Will be honored to work with this committee over the coming months to develop a multidisciplinary approach to a community based mental health and legislative program.

I just wanted to make an additional comment regarding the traditional healer approach. In my own work over the years as a mental health professional, I have had the privilege of working with these people, and I am sure it is not well publicized, but I've seen the progress that these people can make, and we've heard earlier testimony about additional learning or additional training of some of these people that may serve as mental health technicians. But sometimes I think the learning process can occur the other way, that we have lots to learn from them, very much to learn.

So I, again, emphasize the need for us to learn in the other direction.

Finally, the Otoe-Missouria Tribe has a strong friendship with the Navajo Nation of Arizona. My colleagues from the Navajo Community College wished me to submit a statement on their behalf with the testimony I have just presented. And I don't have that with me. They will send that. So, with your permission, I would like to have the privilege of submitting the statement.

Senator EVANS. We will be happy to receive testimony. The record will remain open two weeks for additional statements.

[Prepared statement of Ms. Echo Hawk appears in appendix.]

Senator EVANS. Thank you.

Next, Mr. Edward Wadda.

STATEMENT OF EDWARD WADDA, PRESIDENT, WIND RIVER RESERVATION YOUTH COUNCIL, FORT WASHAKIE, WY

Mr. WADDA. Mr. Chairman, thank you for allowing me to represent UNITY in testimony here.

Since the fall of 1986, youth like myself are searching for ways to make a difference. The Youth Council at Wind River Reservation has been through good times and also has been through a lot of bad times. We also have been through a lot of highs and we also have been through a lot of lows. But we all feel that what we are doing or what we are trying to attempt to do is making a difference, means something to us. Some people might think that we don't believe in what we're doing, but we feel that it can make a difference, other I wouldn't be speaking here in front of you today.

We all have made an impact on our community in one way or another, whether it be through the activities of the Youth Council or whether they went to do something on their own. We have always had that enjoyment of knowing we've done something for our community.

The Youth Council family is growing more and more each day, but, you know, with all the conditions on reservation and stuff, you know, that's another thing that holds back our youth, because they're getting into that stage where they have to make a decision on what they want to do in life, and oftentimes the things that we're talking about here today are taking them away from the right road. Every conference or event that our Youth Council does has some kind of meaning. In other words, everything that a member of our Council does, he is able to share it with not just himself or his family, but he is able to share it with the other members of the council, or anybody else who takes time to listen.

So we have grown in many ways since the fall of 1986. It is kind of bad that we did get started the way we did. Howard Ranier talked about how it got started. In the fall of 1986, there was a suicide epidemic on our reservation, and they brought in a lot of doctors and physicians and stuff on that type of investigating what was happening on our reservation. And the bottom line was that they did not know what was causing these suicides. And there were more than a few suicides. A lot of these men and young gentlemen, ages 14 to—14 was the youngest, I believe, and 28 was the oldest. They all took their lives within a period of time where our reservation was building up, you know, through the years we were taking steps forward, and when this happened, it kind of broke down our government and it broke down the spirit that our people had. They did not want all the media coverage that they were getting, and everything that they worked for was slowly going down the drain, you know.

So with this Youth Council, people started taking pride back into what they were doing, and along with J.R. Cook, he was asked to come and help to see what he could do about what was happening on our reservation. And I guess you could say it was a simple answer, you know, let the youth work among themselves and see if they could come up with an answer. And that's where the Youth Council was born. It took awhile to get going, but after it was born, people started listening to what we had to say.

Our tribal council made us a priority on Wind River, made the youth a priority, and that is we are fortunate because we are only one in five youth councils across this Nation. Of all the recognized tribes, we are proud to say that we are one of the five.

It has been fun working with the people that we have come in touch with, through conferences and, you know, what have you. We will always value their friendship, and we will always be able to count on them when we need them. They are our support to the council, but we also need more support. Each day we will need more support than we did the next day. And so, right now, our council has 22 members covering from the high schools to the communities. Someone that is going to school and is trying for an education is represented on the council and some others that, you know, have the opportunity is also represented on the council. And for us, that was a big help.

The council has been going for about 2 years and each year we get stronger, making presentations, or sending people to different places.

And I have 10 points, or ten major things that our Youth Council has done through the activities. Our Youth Council has sent members to—in the summer, last summer sent members to Minnesota to attend a leadership camp, sort of. Over the summer, you know, they were tested on their skills and given leadership and they were able to share that with our council, and we hope to send more this summer.

And we also sent members to Scottsdale, Arizona, to take part in the Youth and Entrepreneurship Conference that was hosted by the Council for Tribal Employment Rights, which was as part of the Indian YOUTH 2000 campaign this year.

And we sent people to Chandler, Arizona, to attend a youth conference on drug and alcohol prevention.

So just right there you can see we've taken up many different things. We've taken up entrepreneurship we're looking into, and we're taking up looking into leadership, and we're looking into drugs and alcohol.

And also we sent delegates to UNITY. And so, with all of these different conferences we learn something new every day. And it's through UNITY, you know, that our Youth Council got started, and we hope to share that with other people.

We have had some input into tribal fairs. We had some input into conferences. This conference, specifically, that we had, the Wind River Reservation Conference, and we'd bring J.R. up to talk, you know, he was the keynote speaker at one of the conferences, and Vivian has been to our conference.

And we've just had different things. We went to a Winter Fair. We sold membership cards. We also visited our State Capital, and we visited the Governor's mansion, and we decorated his tree, Christmas tree, with Indian ornaments, and it stood there over a month's period and for Christmas.

And we were also able to meet with the Governor of the State of Wyoming.

And also, we took a project just this summer called The Living History of Indian Village. There's a pamphlet. Our logo has a man on one side, they're back to back, a man on one side and a lady on the other, which kind of represents both parties. Our reservation has two different tribes, the Shoshones and the Arapahos. One time they were bitter enemies, and now they have learned to work together. And so that's how our Youth Council is. It also has from each school a representative of both a boy and a girl.

We also are involved in our community. They are giving us support by doing like radio shows. Every once a month we have two radio shows that we go on, and we talk to the people about what activities we have done with the Youth Council, what was on our agenda, you know, the things we've done, our activities and our accomplishments that we have done. We shared these with our people and, you know, a lot of people are starting to realize what our Youth Council is taking up. It's kind of a first, and we're very proud of it, and when we opened our village, that was probably the proudest moment that we ever had, because it was our biggest project we ever took on.

Our goals are very simple. To promote and establish Indian leadership among the reservation youth. To educate the public about the Native traditions for future generations to understand and value the cultures. And to promote activities designed to strengthen the spirit, mind, and body in keeping with Native tradition.

So when I'm listening to some of the other testimony, I came up with some other notes, that the Indian people, they live a very—live a successful, you have to live a balanced life, and at the age of 14, physically, you have to have balance mentally, and socially, and spiritually. And without either of these you will live an unbalanced life, and many of the successful people that do live successful lives are very balanced, and the others, that do not have this balance, are the ones that are taking the hard road, they have been distracted by some of the, you know, the things along the way like alcohol, drugs, and stuff like this.

I don't know if money is the matter. You know, I don't know if money can solve our problem, because with the youth on our reservation we want to be able to bring somebody in. We've been told by Howard Ranier, when we had our leader session, to not leave anybody out. And that's what we want to do. I don't need education, or I don't need money to shake somebody's hand or give them a hug, or tell them to have a nice day. I don't need that. All I need is just to tell myself that I want to be a friend, and I don't think money can buy that.

And finally, what UNITY has done is to start to provide role models, role models such as myself and other people like Monty Larson. Some of them are right here. Would you stand up? [Applause.]

It's people like this, they're my friends. They have become part of the UNITY family as I have. The peer leaders have become a part of the UNITY family when we had our last conference. And I know that throughout the years I'll see them and they'll see me. And I hope that these hearings and what we've testified today can help out in the long run.

Thank you.

[Prepared statement of Mr. Wadda appears in appendix.]

Senator EVANS. Thank you very much for your testimony. [Applause.]

Now we will turn to Ms. Vivian Juan.

STATEMENT OF VIVIAN JUAN, TRUSTEE, UNITED NATIONAL INDIAN TRIBAL YOUTH, OKLAHOMA CITY, OK

Ms. JUAN. Mr. Chairman, committee members, I would like to submit my testimony at this time.

The United National Indian Tribal Youth is a nonprofit organization that I have been associated for seven years, and I currently serve as a member of the Board of Trustees of UNITY.

Without UNITY, I believe that my role would have been a very weak one. UNITY established a network throughout the country of American Indian youths, and as a result of that, I have traveled throughout the country providing workshops for positive development of self-esteem. I have been to 35 States throughout the country, and three-fourths of those visits have been to American Indian and Alaska Native youth activities and communities. I see a great need for qualified and trained people to work with our youth and to recognize that youth are a priority.

How many times have we heard or have we said to youths that they are tomorrow's leaders, that they are tomorrow's future? Five years ago I told people to quit telling me that and start showing me how, start showing me by your examples and start teaching me skills to be tomorrow's leader. And this is what we are focusing on with our program for youth.

And the statistics, 1.5 million American Indians exist today. Half of these live off the reservation, and of this population, half are under the age of 22. Our main priority is to allow youth to have a voice, to allow them to come up with solutions to problems that involve themselves, and with this, some of the solutions that I see are youth centers where youths can have a place to gather. It troubles me when I visit a community for a day or a half an hour, I talk to youth, and someone comes to me and says, "I have no one to talk to, I can't trust anybody when people are hired to do this job." With more training and more appropriations for people to work with our young people and to provide the youth centers, giving them a place to go to when they feel the family life at home is one where they don't want to be at for awhile.

Also people who are trained to manage the youth center, trained and qualified to give counseling.

In 52 years will be the year 2040 and many of us here in this room will not be alive. Our grandchildren will be the ones sitting here in 52 years, and what will be the state of our mental, physical, spiritual, and emotional well-being, what will the state be?

And the only answer I can think of is what our efforts, by our efforts today will determine the stability and continuity of wellness and hope. And I have a strong vision, I have high hopes in our young people that I work with, people like Eddie Wadda. There's hundreds of them throughout the country that I have confidence that, with your help and with the help of the networking that can be established through people that are here today, the future will be a bright one.

[Prepared statement of Ms. Juan appears in appendix.]

Senator Evans. Thank you very much.

Mr. Cook, do you have a statement?

STATEMENT OF J.R. COOK, EXECUTIVE DIRECTOR, UNITED NATIONAL INDIAN TRIBAL YOUTH, INC.

Mr. Cook. Mr. Chairman, I have submitted some written testimony, and, with your permission, I would summarize and make just a few remarks.

Senator Evans. Sure. Please do. Your full statement will be included in the record.

Mr. Cook. We really appreciate the committee and the staff for allowing youth to be a part of the hearing.

A great deal of what UNITY is about is that youth have a voice. I could best describe UNITY by three of our different activities. One was two years ago in conjunction with our National Conference here. We worked with the House Committee on Interior and Insular Affairs in scheduling a special hearing pertaining to the alcohol and drug prevention bill, and we did have over 15 youth testify.

Another was, working with the Wind River Reservation in establishing a tribal youth council, because we do feel that youth have the answers. We feel that youth represent a very great resource that's been underutilized, that after more than 200 years of Federal Government policies, we can take a look at the statistics, the economic and social indicators, and it's obvious that there is still something that needs to be done.

We contend that Indian youth have a lot in common with Rodney Dangerfield, that they haven't received much respect yet, but they're starting to earn a little bit of respect. From the local level, the tribal level, State and national levels, that Indian youth have been talked at, talked to, talked about, and very few people have taken the time to listen. And we think that they have the answers. They have the energy, the enthusiasm, a lot of creativity, and all that's needed is a mechanism through which they can work cooperatively. And I think that they certainly have the ability to turn Indian country around.

In Denver, 1 year ago, at our National Conference, and Ms. Yvette Joseph was very much involved in that conference, the final session was devoted toward the youth identifying what they consider to be the main problems and concerns, and they arrived at a list of the top ten. And after they identified the problems, they spent time brainstorming and looking for solutions. And they made a list of recommendations as to what could be done by the year 2000 to change things.

It's time to stop talking about the problems and start looking for solutions, and that's what UNITY is about. We're really pleased to be involved in launching the YOUTH 2000 campaign for American Indian and Alaska Native youth. This is to be done at the grass roots level. We have been going through a process. We did this in Milwaukee and Akiachak, Alaska, and other communities. It's where the youth themselves identify problems and concerns, and then they spend time working on solutions. So this is really encouraging as to what we have seen happening.

One of our recommendations is we really see the need to continue the development of tribal youth councils, and we would appreciate the support of the committee. Wind River was the first such council that we helped establish. Others are the Northern Utes, in Utah, the Confederated Tribes of Warm Springs, Gila River Indian Community in Arizona, and we're working with the Winnebagos in Nebraska.

Instead of having an annual conference, this needs to be an ongoing effort. We would like to see an institute for leadership training for American Indian and Alaska Native youth established. And there just happens to be a vacant college campus in Oklahoma City. There could be a place that tribes could send us their best so that they could receive some intense leadership training, return back to their respective communities and that they would be prepared to make a difference.

In closing, I want to pledge our support that if there's any way that United National Indian Tribal Youth can be of assistance in working with the committee, with the staff, that you certainly have our support, and at all future hearings, we would hope that youth would be represented.

Thank you.

[Prepared statement of Mr. Cook appears in appendix.]

Senator EVANS. Thank you very much.

And I appreciate the entire panel's testimony.

First let me ask Ms. Echo Hawk: A very interesting and, I think, a valid concern is the integration of traditional medicine with mental health professionals in future activities.

How would you best suggest that this integration take place? Would I be correct in saying that the traditional methods differ fairly widely from tribe to tribe or region to region throughout the country?

Ms. ECHO HAWK. Yes, they do differ. Medicine men/women provide treatment for their own tribal members and their methods would differ depending on their tribe.

Senator EVANS. Integration would have to be done almost on an individualized basis?

Ms. ECHO HAWK. Yes; one would have to develop the rapport or establish some connection to the tribe, and work closely with the community on how to integrate what's already being utilized by the tribe, and then make it available within the Comprehensive Mental Health Centers. Assuming that the concept of integrating Western and traditional ways is valid, now, I'm sure, would be a very appropriate time to invite various tribal medicine men/women, to give you more detailed information on how they would see themselves working with comprehensive mental health centers.

Senator EVANS. Do you anticipate that this would require some additional specialized training or, at least, understanding on the part of the typical mental health professional who has had no contact or understanding of traditional Indian medicine procedures?

Ms. ECHO HAWK. Yes. Yes; it would definitely require some understanding, because, as I mentioned in my brief statement, that many times they've gotten ridiculed, pushed aside, or ignored, so I think there would be hesitancy on the part of traditional healers to readily participate or colaborate with typic mental health professionals. They would want to feel welcome to be able to help in some way, and definitely a solid connection would have to be made, or the invitation would have to be extended, you know, from the people who are planning such centers to invite traditional healers to come forward and help. And that would be done through close community liaison or sensitivity to the community one's involved with.

Senator EVANS. Yes.

Ms. ECHO HAWK. It is not impossible.

Senator EVANS. Right.

Mr. Wadda, some very fine testimony. You can be very proud of your representation of the youth from drouth country, and particularly from your community.

Tell me, with the youth council that you are operating with, and the various activities—it sounds like you're engaged in a wide variety of activities—do you find that a high percentage of the youth of your reservation and your community take part in one, several, or all the activities that you put forward?

Mr. WADDA. Well, on my reservation, there are certain individuals that are like myself, you know, right now they're not able to participate in youth council because they have gone away to like different camps and summer schools, and stuff. But what is unique about our youth council is after they left there was other people to take their place, you know, and they pick up the slack. Right now, I know like back home, I know that everything is under control because, you know, I have trust in them, and they're starting to get more trust in themselves.

But a lot of the kids on our reservation are very distracted and the big thing on our reservation is alcohol. It used to be drugs, it still is, but there's more and more alcohol on our reservation. You know, some of the kids that I feel would make good leaders drink a lot, you know, and on certain days I would come up to them and, you know, ask them, you know, try to talk to them, and then you can see, you know, in their eye just for that one split second, whether it will be just a wink or just a look, or something he said, you know, bring out a whole different person in him, you know, a person that wants to get out and feels locked in. He wants to get out, but, you know, he knows that when he does, you know, his friends are gonna be there to try to bring him down. And through the youth council, I hope in the future that we can, you know, develop some way to bring out these people, you know.

There's a lot of good leaders across the United States. There was, you know, everybody at our UNITY conference, you know, they were all leaders. And every year we can get more and more, but on our reservation we hope to bring out, you know, all we would need is maybe two more, if we could bring them out and they can, then other people can see what's happening, and they could bring out their friends.

But right now, the youth council on the reservation is looking for other people, but, you know, it will take awhile to help, you know, the friends, some of my friends and some of the other younger kids. But every year, maybe by this time next year, you know, we'll be just that much more better. Through the years we hope we can just keep this youth council going until we get it as big as it can be.

Senator EVANS. That is exactly right. I don't care whether you are talking about youth councils or a big corporation, or a senate, or almost anything we do in our society, if you have that kind of an attitude where, you know, we recognize the difficulty of problems and that we won't have instant success, but if we look ahead and figure that we are going to make a little progress next year, it's gonna be better than this year, those are the beliefs that will succeed.

I appreciate that very, very much.

Do you sense the change? The youth council is now what, two years old, or approximately two years old?

Mr. WADDA. Yes.

Senator EVANS. Do you sense the change in attitudes and willingness of people to participate?

Mr. WADDA. Yeah. You know, it can be seen when you go to our village, you know. We've done a lot of, did our home work on this village. We've taken on a project, you know, just to see if we can do it. And first we started out with just an idea from a lady, and then the council took it under their wings and they wanted to try it out and see if they can, you know, help out or see if they can get it done. And as we speak it's open right now, you know. And that's just great, I think, you know. I may not be there, but, you know, I know my friends or the other officers are there to take my place. And when I leave to go to college next year, or in the fall, I know that it will still be there when I come back. That's the confidence I have in our council.

And one of the stories that I shared with our senior staff was about at our village we had nothing but weeds and stuff that we needed to get cut down, and we were cutting down everything else, and right in the middle of our village there was these flowers, and, for some reason, I just went around them with a lawn mower, and now all you see in the middle of our village is just that little flowers. Then they went and painted rocks around it, and stuff, and everybody notices it when they come in. As soon as they come in they see our little thing we have and they say, "Wow." You know, it's the little things that you do day by day that add up, and the progress that you make. And I'm just glad to be a part of what UNITY and our tribal people are trying to do. Not what we're trying to do, what we're doing.

Senator EVANS. That's terrific. I think that in many respects we all have the same problem. If we could only cut away our own mental needs we could see a lot of the flowers that exist there.

Ms. Juan, you said something very interesting in your testimony. You said each generation of youth is continually reminded that they are tomorrow's leaders, tomorrow's future.

I think it was an ordinarily astute observation you made, "Quit telling me that I am tomorrow's leader, try to teach me by your example," and that, you know, that for some of us in our generation have fallen down by not always being the best examples. I guess that maybe the difficult thing we have to do is to at some point break that cycle of not-so-good examples, by voluntarily being the first generation that kind of comes along and provides some examples. It's a tough way to have to do it.

Don't you think that that's almost the kind of boot strap operation that has to go on, for the young to look ahead and see what they would like to be and what they would like to see, and how different today's society is from what they would like? Maybe you have to be the one to do it.

Ms. JUAN. I appreciate your comment, because some of the role models that exist today are not the experts. They have not been educated. But in an additional sense, they provide the respect, and the sharing, and the honoring, and the listening to our young people. And that was one thing I wanted to add was the importance of including our traditions and our culture in mental health, mental wellness.

We also target the youths of urban areas as well. Our conferences bring in the top students, cream of the crop, but many times the students having the problems are left out. So we have gone into the communities. And I remember, I recall a young girl who said, "No one ever told me I was important, no one ever told me that I had a purpose in life." And this was one of those students who we tend to ignore.

Senator EVANS. What is the one thing that you think is most important? In this hearing and, of course, in this committee's activities, we have a certain set of responsibilities.

What would be the most important thing we could do, in your view, to help in the process that you would like to see carried forward?

Ms. JUAN. Maybe it would be respect for one another, respect for our opinions, and respect for the backgrounds that we come from. I think that's the underlying component of human beings, being a human being, and taking—when you take away all the layers, that being an Indian is not ~~how~~ dark you are or how long your hair is, but it's how we see other people. And I believe that the greatest thing that perhaps we can all work together and network, and to come up with some other solutions is what we propose.

Senator EVANS. Edward, from your perspective and your youth council, do you have any ideas of the things that we could do that would be most important to help you in the activities that you're carrying out?

Mr. WADDA. I guess I would just like to see continue to be interested in the youth, being able to hear what they have to say, and let them express their voice and express their opinion. I guess we know that there are certain things that paper, you know, just can't provide for us. And we appreciate, you know, you listening to what the youth has to say, but right now, instead of me, there could be 300 other people, but, you know, I know that we would all be trying to get the same message across, you know. We are just fortunate and we appreciate the opportunity to be here.

Senator EVANS. We thank you very much, and, in fact, I think that is something that certainly has come out of not only this hearing, but the Chairman's real interest in this activity. I would hope that, as time goes on, we will have members, as well as staff, of this Senate Committee, and perhaps others, just on a regular basis taking part with your meetings or national conferences. And others where, you know, The business of the Senate is talking, and sometimes the other half of that is as bad for not listening. And if we can do that, we can be of help.

Thank you very much for some very important testimony, and we are delighted to have you here.

The next panel is Ms. Joann Kauffman-Keefe, Executive Director, Seattle Indian Health Board, Seattle, Washington, and Ms. Pam Jumper-Thurman, Human Services Director, Indian Health Care Resource Center, Tulsa, Oklahoma.

Please go ahead.

STATEMENT OF JoANN KAUFFMAN, EXECUTIVE DIRECTOR, SEATTLE INDIAN HEALTH BOARD, SEATTLE, WA

Ms. KAUFFMAN. Thank you, Senator Evans.

My name is JoAnn Kauffman, and I am the Executive Director of the Seattle Indian Health Board, and I am here today to provide testimony on behalf of the Seattle Indian Health Board, but also the American Indian Health Association, which is an association of urban Indian programs around the United States, and also a recently formed national organization called the National Association for Native American Children of Alcoholics.

First of all, I would like to make a few points about the notion of community-based mental health. It has been my observation in the past 16 years that I've worked in Indian health care, that the Indian Health Service is, by and large, a medical model. That model has been effective in dealing with tuberculosis and maternal and infant mortality, but not so effective in dealing with the nonclinical problems like alcoholism and substance abuse, domestic violence, suicide, homicide, accidents, sexual abuse, and mental problems. I think that needs to be recognized. Second, I think there exists a very important issue that could undermine this effort, and that is the issue of "turf wars" between mental health and alcoholism, between IHS and BIA, between clinical models and social models. And I think that we have a lot of resources out there. We need more resources. We also need to coordinate better around the issues of mental health and community-wide wellness.

The third issue I would like to discuss relates to mental illness and mental health. Given the statistics that we have heard earlier today, I am not sure what the percentage of worried well might be in the Indian population, but I don't think it's a very large percentage.

Based on the estimate that 80 percent of the Indian population over 18 is practicing at some stage of alcoholism, we can also estimate that 80 percent of the Indian children in Indian families are growing up in alcoholic homes.

I think that a significant amount of study has occurred recently around the syndrome that develops in children who grow up in alcoholic settings. Homes which are by and large violent, unpredictable, and not a nurturing environment.

Dr. Candace Fleming, a noted Indian mental health researcher, pointed out that the psychiatric disorders purported to be high among Indian people are largely depression and anxiety, but these are not clinically identifiable but are pervasive across the community and multigenerational in scope.

In Seattle, we have a mental health outpatient counseling program. It is funded by the State of Washington. Because of the State law that provides these mental health funds, we can only see the chronically and severely mentally ill. An example of what this means is an Indian woman who experienced child sexual abuse and has made a decision that she is going to seek therapy for that, cannot be seen in our clinic. However, if she attempts suicide, then she would qualify as being severely mentally ill, and eligible for care.

We have four therapists and they see approximately 157 people per year. Our waiting list has been as high as 75 people who must wait up to 16 weeks for treatment.

There are a large number of other categories that do not fall under mental illness per se, but are critical and important to establish mental wellness and mental health in Indian communities.

We also operate a national demonstration project aimed at breaking the cycle of multigenerational chemical abuse among Indian families. We have taken a model that works with children of alcoholics. In the past two years we have worked with the ten tribes in the Puget Sound area and three urban Indian agencies that we have identified, providing intensive training to people who will then take this information and work with their communities to provide support to children of alcoholics.

What we found is that there is an overwhelming need for more information about children of alcoholics, that many of the people there, upon discovering the information, find that they want to seek continued treatment. There are no resources for that specialized treatment either through the Indian Health Service or through the private sector.

We have also uncovered something that is difficult to come up with a name for, but it seems to be an outgrowth of cultural oppression. We have all seen and heard many accounts about our parents who were punished for speaking their language, about our grandparents who had to burn their Indian clothes when they converted to a Christian religion. As a matter of fact, attached to my testimony is a memo from the Commissioner of Indian Affairs in 1923, notifying Indian people throughout the United States that he will no longer tolerate dances, feasts, give-aways, and other ceremonies that detract from their livelihood of farming and acculturation.

Those types of aggressive, oppressive activities against Indian people are well documented. What has not been assessed has been the multigenerational effect of this cultural oppression on the mental status of Indian people today. What has been the nonverbal or verbal messages that have been passed down from my grandparents to my parents about our culture and how it translates into identity and our current mental health crisis?

We see the need for more research and study on cultural oppression and cultural depression, and we see that any effort around community mental health must also look at cultural feelings, so that Indian people can make a connection again and we can separate out the negatives and the positives and the mixed messages they have received from generations before about Indianness, about spirituality, and about their ability, or it being OK for them to make spiritual expressions in a cultural way, whether that is for their tribe or for those who have lost connection with their tribe.

We also believe that this committee needs to pay close attention to the multigenerational effects of dysfunctional family systems. We have a high percentage of alcoholism and we have heard the information about child abuse and domestic violence. One thing that we know about child abuse and about children of alcoholics is that what is being perpetuated is "the cycle," that these children will grow up and parent the way they were parented. And if their parents were in a home with alcoholism, they are likely to tolerate alcoholism. If they were sexually abused, there is high likelihood that they will become sexual abusers.

We need to look at these multigenerational experiences, and look at ways of breaking the cycle of family dysfunction.

Regarding child abuse, I would also like to point out to this committee and suggest that this research be gathered, by Dr. DeeAnn DeRoin, from Haskell Indian College. She did a study on child abuse and found that, while the rate of total cases reported for Indians was less than total cases reported for the general public, the rate of convictions on those cases was drastically higher than the rate of convictions for the general public. That suggests that only those very gross and undeniably apparent cases are being reported, and that suspected abuse has not been reported.

Next I would like to point out that there is denial within the system, denial within the Indian Health Service, and denial within the BIA, and probably denial within many tribal councils that have not made an outward commitment for sobriety toward wellness and toward mental health. And I think that this denial needs to be addressed.

Senator Daschle asked what could be done now if we had no additional money. My comment to that question would be that intensive training on mental health issues surrounding these people generally needs to be provided to existing staff. And this training needs to be "experiential" in nature, because I would suggest that many of the staff are representative of the Indians and have experienced many of those childhood situations themselves, and that if they are personally still in denial about those situations, it is highly unlikely that they are going to be able to provide quality care to patients who need that type of care.

Finally, I would like to make the following recommendation. I would recommend that this committee establish a multidisciplinary commission to look at community-based mental health.

Second, I would like to see this committee adopt a definition of community mental health which is not restricted to the clinical model but also incorporates and promotes wellness and incorporates the notion of physical, spiritual, mental and emotional balance.

Third, I would like to ask this committee to investigate the effects of multigenerational cultural oppression, alcoholism use, domestic violence, and family dysfunction as it relates to mental status today.

Fourth, I would like to point out the following risk groups that I believe deserve special attention: Child victims of sexual abuse; adult survivors of child sexual abuse; adult children of alcoholics; young children of alcoholics; elderly who are dealing with early mortality rates of family members; Indians with dual diagnosis where they are tossed from one system to the other between alcohol and chemical addiction and mental illness. And also I would like to call attention to Indian people with AIDS and family members who are attempting to provide support for those people.

Finally, I would like to say that today has been very educational for me and very encouraging. It was real nice to hear the folks with the UNITY group. It is also good to hear stories about the movement toward wellness from the Pine Ridge, the Cheyenne River, and Alkali Lake. And I believe that we're on the right road. I think we need encouragement from Congress, we need some support to pool together the various interests and disciplines so that we can work together in a coordinated effort.

Thank you.

[Prepared statement of Ms. Kauffman appears in appendix.]

Senator EVANS. Thank you very much.

Ms. Thurman.

STATEMENT OF PAMELA J. THURMAN, HUMAN SERVICES DIRECTOR, INDIAN HEALTH CARE RESOURCE CENTER, TULSA, OK

Ms. THURMAN. Thank you. I appreciate the opportunity to appear before the committee today.

My name is Pam Thurman, and I am the Human Services Director for Indian Health Care Resource Center. We're located in Tulsa, Oklahoma. And I am told that the 1980 census says that we have the second largest American Indian population in the Nation there.

I am the only mental health person in that facility, so we have quite a load, I can tell you.

Most of the people that live in the Tulsa area, the American Indian people, are in the poverty classification. They don't have funds. The don't have time to pursue any kind of mental health help. And I think that is a big factor that needs to be considered whenever we deal with American Indian mental health issues.

Most of the people that do present, when they come to the clinic, present with a crisis. They're either DUI involved, sexual abuse, child abuse, family crises, financial situation. And when they come in we have to work with them immediately, on the spot.

Most of those people have drug and alcohol involvement. The reason that I bring that up is because some of these people have been in drug and alcohol treatment for 15 times and completed the treatment, so the recidivism rates are very high. And I believe that there are a lot of underlying issues that need to be dealt with, through drug and alcohol treatment, to cut that down.

Two of the things that I would like to suggest would be to include the family members in the treatment process more. That is starting to occur, and I am seeing it more and more in the different treatment centers, but I think that it has to go back to a multigenerational aspect as well. Also, a comprehensive community-based mental health program that is multidisciplinary.

In Oklahoma there is a big move towards institutionalization, and so we're seeing a lot of chronically disadvantaged people come into the clinic with no viable treatment options. They have no medical check, they have no one to make sure that they're adhering to medication compliance.

So that's a problem. They're living on the street, and they certainly don't get any help at that point. With a strong community-based mental health program and a local community board with Indian representation to oversee that, I think that some of the cultural issues could be addressed, the cultural sensitivity, and also the dependency issues could be countered.

Another thing that is important is the multidisciplinary aspect. A lot of the patients that we have come in for treatment have been on Xanex and other kind of medication for "nerve" problems, and they have been on these medications for a long time, and never had a mental health referral. I think that the physicians and social services people that are addressing some of these issues could work better or be more effective if they had a multidisciplinary approach, or a team approach where several disciplines work together to identify these problems and make the appropriate referrals. Then we can really address some of the issues.

A very, very strong coordination of professional services is needed.

Second, there seems to be an expectation, at least in the area that I have been working in, that all of the people respond identically to mental health interventions, and that isn't true. There are a lot of ethnic differences, and in American Indians there are a lot of tribal differences. Dr. Echo Hawk made a statement about the different traditional healing practices from different tribes that could support mental health issues, and I agree with that, and I think with a community-based program that has a local, specific Indian represented community board, some of those issues could be addressed.

I also think that more Indian people need to be encouraged to go into training in mental health professions.

Last, I think that there is a lack of access to and knowledge about programs that are available. Urban and reservation and rural areas usually do have a lot of social service programs available, but the Indian people are unaware that the programs exist, and our clients are unable to withstand all of what they call "bureaucratic runaround" that they get. Many of the special service agencies believe, in error, that our people have a lot of "Indian money" available to them, and they are denied services, or the services are delayed while the clients are required to provide extra documentation that they are not receiving Indian money.

They are also reporting to us that they are treated in a very superficial or hostile manner, and the language and semantic difficulties are a barrier as well.

Our clients are mostly English-speaking. However, they are not very verbal. Often they are dismissed by the State agency workers because of this, and denied services.

With a multidisciplinary approach, some of these barriers could be reduced because a liaison or social service worker could accompany the person to the agency and perhaps do some modeling behavior as well as support the person and make sure that they do access some of the services.

The unemployment rates are real high for our Indian people in Tulsa, and a lot of times the mental health needs are secondary to just the basic survival needs, food, and shelter, and clothing. And so their depression begins a cycle, wherein the depression itself becomes a very debilitating barrier. When they are so depressed, they just simply cannot access the services.

They also lack transportation. There's a lot of losses through homicides, suicide, and family violence, and the depression just really becomes a major barrier.

I think that a community mental health program would be a very good move but I also think that there needs to be a strong community board overseeing that, further I believe there needs to be a stronger coordination of the services that are already out there, because we don't want to add one more service without better coordination.

All of the emphasis on drug and alcohol treatment may give the mistaken impression that chemical dependency is the only mental health problem of American Indians, and it is of great concern, but there are a lot of issues underlying that that need to be addressed at this time. I think that it is a community problem and one that does require legislative consideration and a very strong cooperative effort.

Thank you.

[Prepared statement of Ms. Thurman appears in appendix.]

Senator EVANS. Thank you very much.

Ms. Kauffman, while I think both you and Ms. Thurman are dealing with an Indian clientele who are basically urban and off reservation, separated from a number of their family and certainly any kind of a tribal situation, are there significantly different problems that you see in the mental health field from those who are on reservations compared to those you see in the urban setting?

Ms. Kauffman. I think in terms of the resources that are available, there are differences. I don't know if one is better equipped with resources than the other. It varies from reservation to reservation, and different urban cities have—I mean urban cities have different resources available.

Senator Evans. I'm not thinking so much about the resources available, but what the problems are that you face. Are they a significantly different set of problems of the on reservation community than the urban off reservation Indians?

Ms. Kauffman. I think that they are, speaking for the urban population in Seattle, that you have—we have represented there probably over 200 different tribes from all around the United States. So, in terms of the support network for resource to a traditional Indian from there to a particular tribe, for those people who are not from that particular area, it is hard for them to access those extended family members or tribal resources.

I would say that is probably one of the bigger problems. There is also a lot of people who are disenfranchised, who come from terminated tribes, or maybe who were slightly left in the enrollment of them. We have a large number of Canadian Indians in Seattle. And so that brings a variety of issues also.

Senator Evans. Do you think there is the same situation in Tulsa?

Ms. Thurman. I believe that poverty and alcoholism are major problems on both urban and reservation areas. But I think that the reservation areas have the problems in a more contained area, and therefore they are more apparent, whereas in urban areas they are more diffused. They're still there, but they're more diffused.

Senator Evans. Are you seeing any changes, in the clientele that you see, in the relative difficulty of chemical dependency versus alcoholism?

Ms. Kauffman. In Seattle we're seeing, yes, much more polydrug type of client, who probably has tried just about everything, people coming from mostly from urban areas. But I think we also get people coming from reservations into our treatment center, and they have a variety of drugs and chemicals that are also being used. It is very rare that someone comes with one particular drug or alcohol only.

Senator Evans. In testimony of a previous analyst, from a young man who was testifying, it appeared that alcoholism was becoming a bigger problem comparatively among the youths. I was just curious if that seems to be the same in an urban setting, or is it just a multiplicity of problems?

Ms. Kauffman. Well, alcohol is becoming a bigger problem or as big as the other drugs that youths are using, especially in urban settings, crack, and IV drugs are more accessible.

Senator Evans. You mentioned, Ms. Thurman, something that I think we all have to keep in mind, that we can focus, well it is important to focus on both chemical industry and alcoholism, that they are in many respects symptomatic of something that's a lot deeper and a lot broader. I guess that's the real difficulty, isn't it, to try tc get at those underlying problems and causes?

I guess I should ask the same question I asked of the previous panel. Is there one major thing we could do, with our responsibility and from our perspective, what is it, from either or both of you?

Ms. **Kauffman**. I would say to pass comprehensive legislation that will provide some authority for multidisciplinary teamwork across the various Indian agencies, and training for the staff of those agencies, and for tribal people to set up their own feeling plans for their communities.

Senator **Evans**. Do you feel that we have been far too compartmentalized in the way have dealt with the whole array of health and mental health problems?

Ms. **Kauffman**. I think so.

Ms. **Thurman**. I think so, too.

Senator **Evans**. All right. I think breaking out of those barriers would be very useful.

We thank you for your testimony and for your patience in waiting through what has been a comprehensive and long hearing, but is going to be very valuable for us to have all of this contribution so that we can begin the task of trying to craft something that, hopefully, will be large, comprehensive, active, useful, and I think multidisciplinary. As you know, Ms. Kauffman, very well, from my own experience at Evergreen, multidisciplinary sounds pretty good to me.

Ms. **Kauffman**. Yes.

Senator **Evans**. I think it is a very useful concept that we sometimes forget in our focus on just the narrow thing we happen to be doing.

We thank you all very much for your contribution, and this hearing is now adjourned.

[Whereupon, at 5:20 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Statement By

Dr. Craig Vanderwagon

Director, Div. Clinical and Prevention

INDIAN HEALTH SERVICE

Before the

SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

July 7, 1988

TESTIMONY TO SENATE
SELECT COMMITTEE REGARDING
MENTAL HEALTH ISSUES

I am Dr. Craig Vanderwagon, Director, Division of Clinical and Prevention Services, Indian Health Service (IHS) and I am here today with Dr. Scott Nelson, Director, IHS Mental Health Program, Ms. Phyllis Old-Dog Cross of the IHS Mental Health Inpatient Unit at Rapid City in the Aberdeen Area, and Dr. Marion Zonnis, IHS Mental Health Program for the Navajo Area. We are here to represent the Indian Health Service in this important hearing regarding mental health needs and resources in American Indian/Alaska Native communities. We are accompanied by other officials of the Public Health Service -- Dr. Delores Parron, Associate Director for Special Populations, National Institute of Mental Health; Dr. David Heppel, Director, Division of Maternal, Child, and Infant Health, Health Resources Services Administration; and Mr. Henry Montes, Assistant Director, Office of Minority Health. The Centers for Disease Control (CDC) was unable to send a witness but each of the invited agencies has prepared an attachment for this statement, and we will arrange for any questions for CDC to be answered promptly in writing. We each greatly appreciate the opportunity to participate in this most important hearing regarding mental health needs and resources in American Indian/Alaska Native communities. My initial comments will be limited as Dr. Nelson will address Native American Mental Health issues specifically.

There is a significant upheaval in American Indian/Alaska Native communities. It is characterized by a disruption of the social fabric and it manifests as a set of behavioral problems that feeds a spiral of failure affecting both individuals and the community as a whole. It is recognizable by the problems of chemical dependency and abuse, suicide, homicide, and family violence. These are the hallmark problems that IHS and Tribal health providers confront on a daily basis in hospitals, clinics, individual homes, and communities.

Deaths associated with alcohol, suicide and accidents are significantly higher in American Indian/Alaska Native communities than in the general population. It is particularly devastating in the population of American Indians/Alaska Natives from age 25-44 years the community's potentially most productive adults. In this age group, deaths due to alcohol are almost 6 times more likely than in the general U.S. population. Deaths due to suicide are 1.5 times more frequent than in the U.S. population generally. Deaths due to accidents are nearly three times more likely than in the general U.S.population. These deaths not only take lives of individuals, but can destroy a young family, when a father or mother is no longer present to impart love, guidance, and direction. Thus the future is robbed of a solid foundation.

These health problems have reached a critical point in American Indian/Alaska Native communities. The medical care system so pain-stakingly built to address the scourge of TB, trauma, child birth, childhood illness, and other health problems has been very successful in addressing its targeted medical goals. The core of IHS functions is maintaining and improving the health status of American Indian/Alaska Natives. However, behavioral health issues require a different focus, and cannot be effectively addressed without community leadership and direction. The community can and must identify the issues and approaches to resolution of these health problems. The IHS can and must be an effective helping resource for community efforts, but the community must take on the controlling role, not IHS.

How can IHS be an effective resource to support community initiatives? Examples of how this might occur are to be found in the activities of the alcohol and substance abuse program of IHS. The IHS has provided technical assistance in the development of school-based and community-based prevention activities. The character and populations for these programs was described in a recent IHS publication which we are submitting for the hearing record. The IHS is collaborating with a variety of private institutions to provide training for tribal staff to expand the knowledge and expertise within the community to address substance abuse issues. At the direction of tribal coordinating committees, IHS has funded training for tribal staffs, tribal leadership, and other community members. Service delivery has also been modified based upon input and direction from communities. The alcohol action plan developed in 1985-86 is based upon significant tribal participation. An interagency initiative undertaken at the direction of Secretary Bowen has led to strong and vital coordination of departmental resources in this area.

These are all examples from the Alcohol and Substance and Abuse Program of IHS. These efforts were bases upon both legislative branch and executive branch committment to reducing chemical abuse and dependancy in American Indian/Alaska Native communities. The same sorts of program strengthening are already under-way in mental health activities. The special initiatives team of the mental health program has provided technical assistance and support to 43 communities in the last year. This approach to planned community response to mental health issues holds great promise. But it is only the beginning. Further legislative and executive branch initiative is called for.

The witnesses in our panel represent various components of the Public Health Service. The written materials and comments submitted by this group reflects their activities both independently and collaboratively. The enhancement of these activities in assuring the most effective availability of federal resources in AI/AN communities is the goal of the IHS Mental Health program.

Dr. Nelson will now provide the committee with more specifics about the IHS Mental Health Program.

Mr. Chairman and Members of the Committee:

I am Dr. Scott H. Nelson, M.D., Chief of Mental Health Programs with the Indian Health Service (IHS). I am pleased to be here today to discuss with you the Indian Health Service Mental Health Programs.

THE CURRENT STATUS OF THE MENTAL HEALTH SERVICE SYSTEM FOR AMERICAN INDIANS AND ALASKA NATIVES.

Introduction

The mission of the IHS mental health system is to provide access for all American Indian/Alaska Native persons to mental health services which are appropriate to the nature and severity of the mental illness, high quality, and sensitive and responsive to the cultural values of the individual, family and community.

The IHS national focus for mental health services for American Indians and Alaska Natives is the Mental Health Programs Branch located at IHS headquarters in Rockville, MD. The Branch is one component of the Division of Clinical & Prevention Services in the Office of Health Programs. The Branch staff work closely with tribes, IHS Area and Service Unit staff, relevant HHS and BIA components, and major Indian organizations.

Each of the twelve IHS Area offices has a full or part-time mental health consultant. In about half of the twelve IHS Area Offices, the mental health consultant also serves as the social service consultant. In one-third of the Area Offices, the mental health consultant serves as consultant for both the social service program and for the substance abuse program. The Area Offices serve to allocate mental health funds to Service Units and tribal programs, to provide technical assistance and consultation to local communities and other Area staff, and to monitor and review programs.

At the community level, delivery of mental health services is a responsibility of the local Service Unit operated either directly by IHS (75% of Service Units) or by a tribally-administered program (25% of Service Units). Tribes are increasingly assuming the responsibility for directly operating mental health service programs pursuant to the provisions of the Indian Self-Determination Act, PL 93-638.

Mental Health Problems

Studies indicate that depression is the emotional problem that occurs most frequently in Indian communities, both in adults and children. Usually the depression is related to life events such as death, serious injury, economic issues or marital dysharmony. Often depression is a result of acculturation pressures or of long-standing low self-esteem related to childhood experiences of neglect and/or physical, sexual, or emotional abuse.

Depressed feelings are frequently complicated by use of alcohol or other drugs. The combination of low-esteem, alcohol and the frustration or life circumstances unfortunately often leads to suicide, violence, or other forms of abuse. Suicide, homicide, and accidental death occur more frequently among Indian people than in the general population. The rate of death from suicide, homicide and accidents in young Indian males is more than twice the national average. Many of the accidental deaths are associated with known depression and alcohol use, and are suspected to be suicides.

Other common problems seen by mental health service programs include anxiety, phobias and uncomplicated alcoholism. Serious mental disorders such as schizophrenia and manic-depressive (bipolar) disorders appear to be uncommon in many tribal communities. Further study is required to determine whether or not the incidence of these disorders is in fact low or whether they are underreported.

The Mental Health Service System

Approximately 80 percent of the 127 IHS Service Units have implemented a formal mental health service program. The most common program model is an outpatient service which is staffed by one or more mental health professionals, often with the assistance of a local American Indian/Alaska Native mental health technician. On-call emergency mental health services are also provided outside of usual clinic or hospital hours. Consultation is provided to medical staff on mental health problems and to other service unit and/or tribal programs within staffing constraints. Specialized mental health services for populations such as children and the elderly are minimal to non-existent because of limited resources and difficulties in recruitment of trained specialists.

Inpatient services are available through a variety of mechanisms in almost all Service Units. Some IHS hospitals can accomodate non-violent psychiatric patients for a few days with the continued involvement of the mental health professional staff. More commonly, inpatient services are provided under contract with local general hospital psychiatric units or private psychiatric hospitals. Often, emergency hospitalizations and hospitalizations of long duration are provided by state mental hospitals.

The Indian Health Service operates two short-term psychiatric hospital inpatient units: one of 14 beds at the Gallup Indian Medical Center in Gallup, New Mexico, and the other of 9 beds in the Public Health Service Hospital in Rapid City, South Dakota. These units serve Indian persons from adjacent Areas and are almost always at capacity, with waiting lists for admission.

Native healers provide services in most American Indian and Alaska Native communities. These services often complement Western methods of psychological care for more serious mental disorders, and are often sufficient to resolve situations involving emotional distress.

In many Areas, state or local community mental health programs also provide services to Indian persons with emotional problems. Partial hospitalization, transitional living, and child residential mental health programs be obtained from local or state resources, if available.

Funding for Mental Health Service

In most Areas, the majority of funding for mental health services for American Indian and Alaska Natives people is provided by the line-item categorical appropriation for mental health services in the IHS budget. In fiscal year 1986, this appropriation was $12.466 million. The President's budget proposal for FY 1989 for IHS Mental Health Services is $13.091 million, an increase of $625,000.

Some Service Units use other sources of funds to purchase mental health services. These include hospital and clinic (general health) funds or contract health service funds. In addition, states and localities often provide substantial service to Indian persons through local community mental health programs. Indian people are legally eligible to receive mental health services from the state or public mental health system on the same basis as other citizens; however, they often do not use state or local services because of the perceived lack of sensitivity to Indian people and traditions.

Increased emphasis is being placed on collection of third party revenues by mental health service programs. Some Indian people carry insurance and many others are eligible for Medicaid or Medicare reimbursement.

Mental Health Staffing

As of September 30, 1987, the IHS Areas report 269 staff funded by mental health categorical funds. Of the 269 staff, 221 are direct service staff, while 48 are administrative or clerical. The 221 direct service staff include 70 mental health technicians, 61 social workers, 48 psychologists, 24 psychiatrists, 8 nurses and 10 members of other disciplines. 188 of the direct treatment staff are employed by the Indian Health Service and 33 are employed by tribal organizations. An estimated 40 to 50 additional staff are employed by tribes through contract or direct tribal funding. The estimated total of 260-270 means that, on average, about two mental health direct treatment personnel are available for each of the 127 Service Units.

Conclusion

Most IHS Service Units provide mental health services through an ambulatory mental health service program, and arrange for inpatient services through contracts or arrangements with state mental hospitals.

IHS national mental health staff are working closely with consultants and local Service Units to improve the program within the resources available. Current activities include:

- an active quality assurance program, which includes reviews of mental health programs pursuant to recently promulgated standards,

- a team of professionals available for consultation to tribes, IHS and other field personnel regarding strategies for prevention of suicide and other forms of violent behavior, and

- increased planning efforts, including the development of a national American Indian/Alaska Native mental health plan and Research Agenda (both under preparation).

This concludes my prepared statement. I will be happy to answer any questions that you may have.

HRSA

Office of Maternal and Child Health Activities Relating to the Mental Health of Native American Children

HRSA, through the Office of Maternal and Child Health (OMCH), administers a State block grant program which provides a broad range of preventive, primary care, and habilitative services to mothers and children. In FY 88 the States received $444 million through this program under the authority of Title V of the Social Security Act. In addition, 15 percent of the Title V funds are set-aside for grants administered by the national MCH staff for special projects of regional and national significance (SPRANS) in the areas of research, training, hemophilia, genetics, and special projects. A total of 460 projects were funded in FY 1987 and $78 million will be spent in FY 1988 to fund approximately 490 projects. Typical recipients of these SPRANS grants are State and local health departments; colleges and universities; and public and private hospitals, organizations, and foundations involved in providing health care to mothers and children.

Providing mental health services to Native American children is not a focus or objective of the SPRANS grant program. However, since Indian tribes and organizations representing their health care needs are eligible for SPRANS grants, a number of the SPRANS projects include Native American children in their populations served.

Over the last several years, four SPRANS projects are relevant to the mental health of Native American children:

1. The University of Minnesota developed and implemented a questionnaire that was administered in the Minnesota secondary school system in grades 7 through 12 to measure aspects of adolescent behavior and attitudes with respect to their health status and preventive care. In cooperation with the OMCH, the IHS provided funds to modify this questionnaire for use as an IHS prevention initiative and it is currently being administered nationally to collect data from Native American adolescents.

2. OMCH supported a project focused on injury prevention among Native American teenagers in New Mexico. The objectives are to study the problem, establish a clearinghouse and identify at least 5 actions to reduce adolescent injuries. Then, prevention materials and methods are to be developed and teachers will be trained in their use.

3. Another SPRANS project in New Mexico deals with the problems faced by parents of Indian handicapped and chronically ill children with respect to access to care. The study will work with families to identify cultural, institutional, and policy barriers to health care and conduct workshops designed to help parents overcome these barriers and gain effective access to care.

4. In Oklahoma, a SPRANS project, the "Coordinate for Kids Family Support Project" works with local community groups to develop informal support networks, and outreach to parents concerning crisis intervention, child abuse and effective communication. This program is directed to families with young children, including Native Americans, with disabilities and other special health care needs.

CENTERS FOR DISEASE CONTROL/INDIAN HEALTH SERVICE

COLLABORATION ON INJURY CONTROL

The Centers for Disease Control (CDC) serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States. Consistent with this mission, CDC conducts and supports prevention research focused on the development and evaluation of strategies to prevent intentional (violence related) and unintentional injuries; plans, establishes, and evaluates injury surveilllance systems and facilitates such surveillance by State and local agencies; develops, implements, and evaluates demonstration programs to prevent injuries; provides technical assistance; and supports the dissemination of findings from its activities to appropriate agencies and organizations.

Recognizing that injury is the leading cause of death among Native Americans, CDC and the Indian Health Service (IHS) entered into an Interagency Agreement in 1985 to foster collaborative work on injury surveillance and intervention program development, implementation, and evaluation at three selected Indian demonstration sites. CDC has assigned a physician/epidemiologist to IHS, who is assisting with the development of an Indian Mental

Health Research Agenda. In addition, CDC has completed a comparative analysis of intentional and unintentional injuries at the three sites; these analyses have characterized the unique injury problems at each site. These findings were presented to IHS and at the annual meetings of the American Public Health Association and the U.S. Public Health Service Professional Association. Ongoing injury surveillance systems are now operating at each site to monitor trends and to provide additional information to focus and evaluate prevention efforts. Intervention program plans that encompass unintentional injuries, homicide and suicide, and injuries that are alcohol related are now under development.

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) PROGRAMS ADDRESSING THE NEEDS OF AMERICAN INDIANS AND ALASKA NATIVES

Since 1981, the primary activity of National Institute of Mental Health (NIMH) has been to support and conduct research on mental illness and on topics that are seen to promote mental health as well as to provide training opportunities to people who plan to pursue careers in mental health research.

- Mental Health Services

With enactment of the Omnibus Budget Act of 1981, 25 Federal grant programs for the support of health, mental health, and substance abuse service programs were consolidated into the "block grants" that now are provided directly to the States.

Prior to the introduction of Block Grants, NIMH had been directly responsible for the support and administration of the Federal community Mental Health Centers programs. Today, all federal funds for alcohol, drug abuse, and mental health service programs are dispensed in the form of an ADM Block Grant.

This change in funding policy does not mean, however, that the Institute, or the Agency, has no further involvement in services. The Institute, in exercising its "national leadership" role provides technical assistance or consultation to the States when it is requested. The thinking is that since the States have primary responsibility for the provision of services, they should also have the authority to determine how they are designed and organized. But there is a considerable amount of expertise at the NIMH and in other parts of the federal establishment for helping states to carry out their responsibility and the leadership role makes our collaboration possible.

Should they be interested, American Indian tribes are eligible to request professional consultation directly from the Institute if they feel there is a need for any type of technical assistance in designing and developing a mental health service program. No funding is involved; that would need to be sought through appropriate, designated agencies. But assistance is available.

The NIMH Child and Adolescent Service System Program (CASSP) is a State grant program aimed at the development of more effective and appropriate service systems for seriously emotionally disturbed children and adolescents. A major goal of CASSP is the development of service systems that are appropriate to the special needs of minority populations served by the States. The American Indian population is one of the four major cultural/ethnic minority groups served by the CASSP minority initiative.

Several CASSP grants have special foci on American Indian populations, and one, local level CASSP demonstration on Kodiak Island, Alaska, is totally native Alaskan. The Alaska State grant also has special emphasis on native Alaskan populations and has special local native projects in Bethel and in Kotzebue.

The Idaho State CASSP project includes a "paid volunteer" component providing child companions for seriously emotionally disturbed children and adolescents, with a particular emphasis of recruiting and training American Indian companions to help serve this population.

The Oklahoma State CASSP project has assumed the task of developing a statewide screening, early detection and prevention program serving American Indians who are at risk for Fetal Alcohol Syndrome. The Oklahoma CASSP has also just sponsored a national meeting on the mental health needs of American Indian Children and Adolescents, co-sponsored by the Indian Health Service.

The Wisconsin State CASSP project was instrumental in the establishment of two demonstration projects in Northern Wisconsin involving Indian tribes. These projects are funded through block grant monies.

The CASSP Technical Assistance program has a major minority focus. American Indians are one of the four minority populations within the CASSP Technical Assistance Minority Initiative. This initiative is building a base created at a National Minority Children's Mental Health Conference in 1986. At this time the major objective is the development of the model of a culturally sensitive community service system for seriously emotionally disturbed children and adolescents. This project is being co-authored by an American Indian.

CASSP is also negotiating with the Indian Health Service to develop an initiative to encourage State/IHS/Tribal collaboration in the development of State service systems for seriously emotionally distrubed children and adolescents.

The NIMH Community Support Program (CSP) serves needs of American Indians through two CSP Demonstrations in New Mexico:

1) Geriatric Population (FY 87) - $95,740 (Grant is in the second year of a three year grant).
   Target Area: Santa Fe and Sandoval Counties with assertive outreach to two American Indian Pueblos--The Pueblo of San Felipe and Teseque Pueblo.
   Goals: The project provides outreach, team crisis intervention, case management, counseling and educational workshops to its American Indian elderly. An Elderly Advocacy Group will be formed. The project

receives technical assistance, training and psychological services from the neighboring mental health center, La Buena Vida.

At Teseque Pueblo, Open-Hands, Inc., extends comprehensive mental health services to the elderly. Education of primary care physicians on needs of the targeted population is conducted and a community-based advisory board governs the program.

2) Young Adult Population with Substance Abuse (FY 87)-$159,886 grant is in its second year of a three year grant). While this project focuses mainly on the Hispanic Population services are extended to and intended to include American Indian young adults (Isleta Pueblo) in the target area.
Targeted Area: Southwest Albuquerque with special outreach to the Isleta Pueblo.
Goals: Targeted to young adults (18-40) who have a long-term disabling mental illness and substance abuse problems. The project extend assertive case management under the auspices of a satellite clinic of the University of New Mexico's Mental Health Center. The project incorporates elements of the psychosocial rehabilitation model emphasizing cultural and self esteem building activities aimed at enhancing client functioning, early and countinuous family involvement, and training and development of staff.

NIMH Program for the Homeless Mentally Ill--Activites Concerning American Indians

On July 22, 1987 tHe President signed Public Law 100-77, the Stewart B. McKinney Homeless Assistance Act. This Act authorized approximately $1 billion over fiscal years 1987 and 1988 for a comprehensive range of shelter, food, housing, health and mental health care, education, job training, and veterans assistance services. Section 611 established a "Block Grant Program for Services to Homeless Individuals who are Chronically Mentally Ill." Funds are available under this program for outreach services, community mental health services, referrals to health services and substance abuse treatment, staff training, case management, and supportive and supervisory services in residential settings. Funds are distributed to the states on the basis of a formula, weighted toward urbanized states; no state received less than $275,000. Several southwestern and northwestern states (notably Wyoming, South Dakota, Arizona, and Oklahoma) are including American Indians among the homeless mentally ill individuals who will be served by programs receiving block grant funds. Special emphasis in these states is placed on outreach services and on serving clients in a culturally sensitive manner.

On December 7-8, 1987, the NIMH Program for the Homeless Mentally Ill hosted a workshop on the "Service Needs of Minority Persons who are Homeless and Homeless Mentally Ill." Participants included researchers and service providers with expertise concerning minority homeless persons. Also present were several former consumers of mental health services and a family member who were knowledgable about minority issues. Nancy Fernandez, a human services planner and AMI member from Seattle, spoke about an innovative family support program that was started at the Coleville Indian Reservation by an American Indian social worker. The unique aspect of this support program is the inclusion of both family members and consumers.

o Research

In recent years the NIMH research program has been an increasing emphasis on mental illness specifically--the schizophrenias, depression and manic depressive illness, the anxiety disorders, and the mental disorders that occur during childhood and old age. This emphasis on mental illness is not exclusive, but it reflects a shift away from the trend in the 1970s for mental health research monies to be directed toward much broader social problems which neither the Institute nor the field really had the capacity to address effectively. It was felt the responsibility of the Institute more properly concerned the immediate needs of people who suffer mental illness. When other problems such as poverty or homelessness are seen to impinge on mental health, we attempt to work with those agencies which are directly responsible for the particular problem.

The centerpiece of NIMH research support efforts directed toward American Indians and Alaska Natives is the National Center for American Indian and Alaska Native Mental Health Research opened in April 1987 at the University of Colorado Health Sciences Center. The primary objectives of the center are to identify the psychiatric and psychological probems affecting American Indian and Alaska Native populations, to promote and coordinate research projects designed to improve mental health service delivery systems and to provide clearinghouse services to individuals interested in Native American mental health research. The center is a program of the School of Medicine, Department of Psychiatry, and is the only minority group mental health research center concerned with the mental health of American Indians and Alaska Natives. It is funded by a $1.25 million grant from NIMH and involves approximately 25 national research associates and institutional affiliates. Spero Manson, Ph.D. is the principal investigator. Funding provided in FY 1987 was $409,592.

In Fiscal Year 1987, the NIMH supported 4 other studies that will provide information on the mental health concerns of American Indians for a total of $1,090,303.

o Research Training

The Biometric and Clinical Applications Branch of the Division of Biometry and Applied Sciences is currently funding one grant project that has off-reservation American Indians as its research focus. The project is a postdoctoral fellowship for two years, to Philip D. Somervell, Ph.D., University of Colorado. In addition to receiving training in ethnographic research methods as part of this fellowship, Dr. Somervell is conducting evaluation research on a treatment program established by Denver Indian Health and Family Services for chemically dependent, off reservation Indians in the Denver area. Some of these Indians are long-term urban residents; others move between their reservation and the Denver area. The total FY 1987 cost of this project was $26,004. The projected FY 1988 cost is $27,000. Dr. Somervell's sponsor for this postdoctoral fellowship is Spero M. Manson, Ph.D., Director, National Center for American Indian and Alaska Native Mental Health Research, University of Colorado Health Sciences Center, Denver.

The Minority Research Resources Branch of the Division of Biometry and Applied Sciences Funds:

Minority Access to Research Careers (MARC) which develops minority researchers and educators in the fields of substance abuse and mental health through support of undergraduate honor students and faculty fellowships; and Minority Fellowship Program (MFP) which supports pre-doctoral fellowships for research training in mental health disciplines. One MARC trainee and 3 MFP fellows are American Indian.

o Clinical Training

Beginning July 1, 1988, the Clinical Training Branch of the Division of Education and Service Systems Liaison will support four continuation grants in its portfolio focusing on the training of American Indian students. An additional two projects are in the Educational Training Branch proposed FY 1988 spending plan.

One of the new grant projects will provide a specialized psychology internship program focusing on the assessment and treatment of seriously emotionally disturbed children and adolescents for two American Indian doctoral students in clinical psychology at the University of Colorado ($53,580).

Another important goal is to expose the five current predoctoral interns to the particular mental health problems and needs of the American Indian population during their training years.

The second training project for Fiscal Year 1988 funding is to support 10 minority psychiatric nursing students at Arizona State University ($74,084). The main focus will be to improve the existing curriculum by emphasizing special content, research, and clinical interventions related to treatment of schizophrenia and chronic mental illness. Native American Indian students comprise approximately one-third of the minority enrollment in the school of nursing.

Two of the continuation clinical training projects are located in schools of social work. The University of Utah ($88,071) has a training program for American Indians for the past 15 years. In their application, the School requested 10 student stipends per year for three years. The purpose of the training program is to clinically train ten American Indian graduate school students for practice with American Indian clients. The School of Social Work has been extremely successful in recruiting Indian students into their programs.

The remaining two continuation grants are located in departments of psychology. A program at the University of Utah ($59,217) offers M.S. degrees in counseling and school psychology and Ph.D. degrees in a APA-approved combined professional-scientific psychology program. To accommodate the bicultural and bilingual needs of American Indians, culturally relevant didactic and experimental oriented materials will be infused in the program. Training will occur partly on the campus of USU and at prearranged regional field sites located in areas with significant American Indian populations.

The second psychology grant is located at Oklahoma State University ($50,000). It offers a clinical psychology program leading to a Ph.D., and has an excellent record in recruiting and training minority students, particulary of American Indian backgroud.

Testimony for the Senate Select Committee on Indian Affairs

The Office of Minority Health (DHHS/OASH/OMH)

In the preface to the Report of the Secretary's Task Force on Black and Minority Health, Secretary Heckler confirmed the continuing disparity in the burden of death and illness experienced by minority Americans as compared with the nation's population as whole. The Report of the Secretary's Task Force on Black and Minority Health issued in August 1985, identified six principal disease categories that together account for more than 80 percent of the mortality observed among minority groups in excess of that in the white population. These are:

- Cardiovascular and cerebrovascular disease
- Cancer
- Chemical dependency
- Diabetes
- Homicide, suicide, and unintentional injury
- Infant mortality and low birthweight.

While mental health is not directly cited, each of these causes of excess deaths in Native Americans has substantial mental, emotional and behavioral health components.

The formal establishment in December 1985 of the Office of Minority Health (OMH) within the Office of the Assistant Secretary for Health, Department of Health and Human Services (DHHS) resulted from concerns raised by the Task Force Report. OMH was charged to serve as the DHHS focal point to insure implementation of the recommendations of the Secretary's Task Force Report and to monitor DHHS progress in achieving its objectives. To accomplish this, OMH works closely with the DHHS, particularly PHS, in a coordinative and advocacy role, as well as carries out programs of its own.

As part of the cycle of internal review, analysis, and planning, the OMH directs the annual inventory and evaluation of current DHHS programs addressing minority health issues through nine Health Issues Working Groups (HIWG's). The formation of the HIWG's established a departmental body responsible for identifying gaps and needs in the following issues as they relate to minority health:

- Research
- Prevention activities
- Access to and financing of health care
- Health data
- Health care manpower
- Cancer
- Cardiovascular and cerebrovascular diseases
- Chemical dependency
- Diabetes
- Homicide, suicide, and unintentional injuries
- Infant mortality.

Health of Native Americans

Native Americans have the highest rates of injury and death from non-disease causes. Motor vehicles are included in nearly half of all accidental injuries, and the rate of such accidents among Native Americans is higher than that of any other group. There may be a number of psychosocial reasons for this. Nearly one out of every four Native American households is headed by a woman, and approximately half (48 percent) of Native American women are employed outside the home. The overall educational attainment of Native Americans is the lowest of all minority groups. The 1980 Census revealed that fewer than one out of three (31 percent) have graduated from high school and that only 7 percent hold college degrees.

Likewise, median family income is well below the national level. In 1979, it was $15,900 per year, which is $7,200 below the level for whites. Twenty-nine percent of American Indian families lived in poverty in 1979; this is similar to the overall poverty rate among Black and Hispanic minorities but substantially higher than the poverty level of Asian/Pacific Islanders and of the non-Hispanic whites. The unemployment rate among American Indians in the civilian labor force in 1979 was more than 13 percent.

The mores and cultural patterns imposed upon Native Americans have disrupted their traditional way of life. A sense of powerlessness and hopelessness has often been observed as a result and is certainly related to the high incidence of alcohol abuse, suicide, depression, and obesity among this population. The medical and socioeconomic consequences of alcoholism, which is sometimes viewed as a way of coping with cultural disruption, are extensive and tragic; they include death and injury from motor vehicle accidents, assaults, family violence and disintegration, and alcohol-related disease. Alcoholism also contributes to instability of the work force.

American Indians, however, are also observed to draw upon traditional sources of strength to cope with stressors. Traditional strengths include the family, the tribe, and the land itself. Yet, in addition to the high rate of female-headed households, many American Indian children leave their homes today to go to boarding schools. Many of those who have studied the problems of the American Indian family believe that this practice has weakened, rather than strengthened, family stability. For these and other reasons, Native Americans are particularly at risk of dying from causes which are associated with poor mental and emotional health and low self-esteem, including alcoholism, other substance abuse, homicide, suicide, and unintentional injuries.

In Native Americans, eighty percent of excess deaths occurring before age 45 and 99 percent of the excess deaths up to age 70 are due to six causes. These six causes, in order of greatest contribution, are: unintentional injuries, cirrhosis, homicide, suicide, pneumonia, and diabetes. Deaths from unintentional injuries account for 48 percent of excess deaths for males and 40 percent of the excess deaths for females (up to age 45). Cirrhosis accounts for 11 percent of the male excess and 20 percent of the female excess deaths prior to age 45. Homicide accounts for 9 percent and 8 percent of the excess among American Indian males and females under age 45, respectively.

From these causes, it would appear that alcohol abuse is one of the most serious contributors to premature deaths among adult American Indians. A significant mental health factor is obviously operating to result in such outcomes. Too few Native Americans are sampled in the National Health Interview Survey to derive population-level prevalence estimates for selected diseases and disability associated with mental health. Clearly, more needs to be known about environmental and psychosocial contributors to the widespread abuse of alcohol by young Native Americans if the premature loss of life in Native Americans is to be prevented.

OMH Programs for Native Americans

In response to the recommendation of the Secretary's Task Force on Black and Minority Health to "Build the capacity of the non-Federal sector to address minority health problems," the Office of Minority Health developed and maintains a Minority Community Health Coalition Demonstration Grant Program. This Program is designed to fund projects which provide for community based risk factor reduction interventions which target specific minority populations through the work of a coalition of community-based organizations. The risk factors to be addressed in this grant program are related to the six health problem areas identified in the Task Force report which account for over 80% of the excess deaths in minority populations.

This grant program was established in Fiscal Year 1986 when it awarded its first six grants. Over 600 requests were received for copies of the application kit that first year. Over 160 completed applications were received. In Fiscal Year 1987 over 850 requests were received for copies of the application kit and six grant awards were funded from among the 138 completed applications received. Fiscal Year 1988, over 600 requests for copies of the application kit were received and about 100 completed applications received. These numbers are significant because they are symptomatic of the substantial unmet need and intense interest that exists in our minority communities for health promotion and disease prevention activities.

We believe that this unmet need surfaces in a number of ways in Native American communities. We see the mental health problems in a person's life from a holistic point of view, that is, these problems affect the entire person in relation to every aspect of his/her life and the lives of their families. Therefore, dealing with other health problems can play a significant role in getting at the mental health problem. Moreover, such a view is culture-syntonic for minority groups for whom the mind-body dichotomy is not as clear-cut as it is in Western culture. For example, one of the Office's grantees from

Fiscal Year 1986 is a coalition sponsored by the Seattle Indian Health Board to develop and maintain a project on adult children of alcoholics (ACOA).

This project set up an ACOA Indian Alcohol Prevention Team with the approach of infusing into existing tribal and urban systems the needed training and theoretical framework to more precisely address alcohol related family dysfunction and patterns. The project intervenes in this cycle of dysfunction through community education, awareness and support groups. Some observations of the project staff view alcoholism as an intergenerational disease that is passed on "...through dysfunctional behavior, excessive losses and unresolved grief." They further observe that, "As Native Americans, we also suffer from cultural depression which manifests itself in feelings of oppression, alienation, anti-social behavior, lack of positive identification to 'Indian ways,' and poor self image. Intervention is crucial to rebuilding families, tribal strength, positive cultural foundation, and community wellness." Thus it appears that strong mental health support is needed as we look to deal with other health problems such as alcoholism.

Another example from the OMH grant program regarding the relation of mental health to other health problems in Native American populations is our Injury Control Minority Health Project in Robeson County, North Carolina. About one-third of the population of Robeson County is Native American. There is a high incidence of automobile accidents among the younger Native

Americans in the County. Project staff tell us that speeding around dangerous curves is a major cause. They relate the cause for speeding to the need to demonstrate a "macho" image because of feelings of oppression, alienation and poor self image that exist among this group. Again, a public health problem exhibits a mental health dimension.

Another major way the Office of Minority Health attempts to build capacity in the non-Federal sector as well as provide needed information on minority health is through the Office of Minority Health Resource Center (OMH-RC). The Office of Minority Health Resource Center was established by the U.S. Department of Health and Human Services Office of Minority Health (OMH) in October 1987. The Resource Center maintains information on health-related resources, which target Asian/Pacific Islanders, Blacks, Hispanics, and Native Americans available at the Federal, State, and local levels. In addition to serving as a central source of minority health information, the OMH-RC works with the Office of Minority Health in identifying gaps and in stimulating the development of information resources where none currently exist. The Resource Center also fosters a reciprocal relationship with health professionals where information is not only provided, but exchanged.

The activities of the OMH-RC concentrate on the priority areas and associated risk factors and crosscutting issues identified by the Secretary's Task Force on Black and Minority Health. These activities include information and referral services, database development, development and maintenance of a national resource persons network, and the development and identification of useful publications.

OMH AIDS-Related Activities

While Blacks and Hispanics are over-represented by more than a two-to-one ratio among those with AIDS, Native Americans so far do not show a disproportionate representation among AIDS cases. However, Native Americans are very much at risk of AIDS because AIDS is a disease transmitted by behaviors which are present in every racial group. To address the behavioral aspects of education and prevention of AIDS in local communities, OMH is funding innovative local programs using community-based organizations.

In Fiscal Year 1988 OMH will support AIDS education and prevention projects through grants to minority community-based organizations and national organizations. Recognizing the need to build the capacity of minority organizations to design, implement and evaluate effective prevention/intervention programs, OMH is planning a technical assistance effort as an essential component of our AIDS program. Nine "pre-application workshops" have been conducted this year, and other technical assistance mechanisms are being planned for next fiscal year.

TESTIMONY OF DENISE DOUGHERTY, PH.D.

U. S. CONGRESS OFFICE OF TECHNOLOGY ASSESSMENT

BEFORE THE

U. S. SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

ON THE JUSTIFICATION FOR CREATING A COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH INITIATIVE TO ADDRESS THE MENTAL AND EMOTIONAL HEALTH CARE NEEDS OF AMERICAN INDIAN AND ALASKA NATIVE PEOPLE

July 7, 1988

Mr. Chairman, I am pleased to appear before you to present testimony to the Committee on issues of mental health.

Mr. Chairman, the Congressional Office of Technology Assessment has completed two reports relevant to this topic. The first was Indian Health Care, published in April 1986 (U. S. Congress, Office of Technology Assessment, 1986a). The second was the background paper, Children's Mental Health: Problems and Services, published in December 1986 (U. S. Congress, Office of Technology Assessment 1986b). The Senate Select Committee on Indian Affairs supported our study of Indian health care, and you and Senator Hatfield requested the study of children's mental health through the Senate

Appropriations Committee. We have just begun a broad assessment of adolescent health, also at your request. This study will address issues related to the mental health of American Indian and Alaska Native adolescents.

OTA's study of Indian health found strong evidence of mental health problems among American Indians and Alaska Natives. The existence of mental health problems can be inferred from the incidence and prevalence in a population of the so-called "social" or behavioral causes of deaths -- accidents, homicide, suicide, and deaths due to substance abuse. These causes accounted for a much greater proportion of deaths among Indians than they did for the United States population at large (table 1). Accidents, for example, caused more than three times as many Indian deaths than deaths among the U. S. all races population, and were the second leading cause of death among Indians, compared to being the fourth leading cause of death for the Nation as a whole. While homicide is the eleventh leading cause of death in the population at large, it was the eighth leading cause of death among Indians; on average, an Indian was twice as likely as a member of the U. S. all races population to die as a result of homicide. The average death rate due to suicide, the ninth leading cause of death among Indians, exceeded the U.S. all races rate by a ratio of 1.7. Alcohol abuse is implicated in Indian deaths and illnesses from many causes, including accidents, suicide, homicide, diabetes, congenital anomalies in infants, pneumonia, heart disease, and cancer. Perhaps the strongest indicator of alcohol abuse is the incidence of chronic liver disease and cirrhosis, much of which can be attributed to widespread abuse of alcohol among Indians. The death rate from chronic liver disease and cirrhosis was 4.2 times that of the U. S. all races rate, and it was the fourth leading cause of death among Indians, compared to being the eighth leading cause of death for the U. S. all races population.

What is perhaps most disturbing about the causes of death that can be attributed at least in part to mental health problems is their prevalence among younger Indians. As with the U. S. population in general, the leading causes of deaths among Indian adolescents aged 15 to 24 are accidents, suicides and homicides. But the death rates for these causes among Indian youth far exceed the rates in the population at large (table 2). The death rate for accidents among Indian young people is almost three times that of the population at large; for homicide it is twice the rate. The Indian youth suicide rate is 3.2 times as great as that of the youth population at large. Further, Indians 15 to 24 have the highest suicide rate of all Indian age groups, while among the general population, the suicide rate generally increases with age.

Although it is not a leading cause of death for Indian adolescents, the prevalence of alcohol use among younger Indians can be determined in part by the fact that while deaths from chronic liver disease for the U. S. all races population climb steadily beginning in the 25 to 34 year old age group and peak in the 65 to 74 year age group, the pattern for Indians is quite different. The death rate for Indians aged 25 to 34 is about what it is for the general population aged 55 to 64, and the death rate peaks between ages 45 to 54. Even those Indians ages 15 to 24 have a death rate from liver disease that is eight times that of the U. S. all races population of that age.

The extent of teen age pregnancy in a population may also be an indicator of the need for mental health and social services. In 1980, 25 percent of Indian births were to girls 19 and younger, compared to a teenage pregnancy rate of 15 percent for the U. S. population at large.

In addition to statistics for mortality and teenage pregnancy, there is considerable eviden. from small scale studies of problems that could benefit from mental health services. For example, many Indian children suffer from cognitive deficiencies associated with a high rate of otitis media, from depression, poor self-esteem, conduct disorders and delinquency (McShane, 1988; Yates, 1987). Some suffer from the effects of out-of-home placements in foster home and boarding schools, or from the effects of neglect and abuse that lead them to be placed in alternative settings (McShane, 1988; Yates, 1987). But as the Indian investigator LaFromboise has recently pointed out, only a very few community-wide American Indian epidemiological studies of psychopathology exist (LaFromboise, 1988). In addition, many of the studies are dated (Yates, 1987).

Mental health problems are not surprising, given the poor living conditions of most Indians. There is substantial evidence that poverty, unemployment and living in a single parent home pose significant risks for the development of mental health problems (U. S. Congress, OTA, 1986b). OTA found unusually high rates of these risk factors among Indians. In 1979, the median income for American Indian families was $13,678; for Indians living on reservations, it was $9,924. These figures compare to a median income for U.S. families of all races of $19,917. As reported by the U. S. Census, the 1980 unemployment rate among Indians was twice that of the U. S. all races population; among reservation Indians, it was four times the U. S. all races rate. As might be expected, a greater proportion of American Indian families lived below the poverty level: more than twice the 12.4 percent rate for the U. S. all races population. Poverty among Indians living on reservations is significantly higher, with 44.8 percent of persons living below the poverty line in 1979. Single parent families are more likely to be living in poverty as well as to have other stressful conditions conducive to the development of mental health problems. In 1980, approximately 22 percent of American Indian and Alaska Native families were maintained by women, compared to a rate of 14 percent for the U. S. all races population.

Our study of children's mental health was done primarily to learn the extent to which the mental health field has reached a consensus on the appropriate treatments and treatment settings for responding to the mental health needs of our nation's children. It examined the nature of children's mental health problems, the mental health services available to aid disturbed children, and the Federal role in providing services. Our review of children's mental health services indicated that a comprehensive system of mental health services would include:

o preventive services;

o a full range of treatment services, including outpatient care, partial hospitalization, inpatient care, and residential treatment centers;

o case management and advocacy for children;

o services that are community-based;

o services to families as well as those that are directed to individual children and adolescents;

o services that are coordinated across the mental health, general health, social services, educational, and juvenile justice systems.

We found, however, that most children in need do not receive the full range of necessary and appropriate services to treat their mental health problems effectively. To date there has been no national study of the mental health needs of American children. But the epidemiological studies that have been done indicate that 15 percent of all our children require mental health treatment. From the data available to us, it appeared that 70 to 80 percent of children in need of mental health treatment were not receiving care. Although there seem to be shortages in all forms of children's mental health care, there is a particular shortage of community-based services, case management, and coordination across child and adolescent service systems.

We cannot report to you at this time whether the conclusions we drew about the mental health needs of the Nation's children apply to American Indians and Alaska Natives. As you know, OTA's study of children's mental health problems and services was not a full OTA assessment. That study did not have the resources to address specifically the mental health needs of American Indian and Alaska Native children, nor to evaluate the mental health services provided to them. There are, however, some indications from our Indian health study that the mental health services available to Indians are less than optimal. For example, OTA's Indian health study found that the hospitalization rate for mental disorders in Indian Health Service hospitals is about 20 percent lower than that in U. S. short-stay general hospitals. In addition, the rate for alcohol-related mental disorders was considerably higher than the U. S. average, meaning that hospitalization for non-alcohol-related mental disorders is much lower than the national average. Undoubtedly, one reason for this low utilization rate is that there are only 72 psychiatric beds in the entire Indian Health Service system (Statter, 1988). This lack of hospital beds does not mean that sufficient services are being provided on an outpatient basis. Despite the prevalence of mental health problems among Indians, mental health reasons were not among the 15 leading causes of outpatient visits to Indian Health Service clinics.

At your request, Mr. Chairman, OTA will study mental health services available to American Indians in order to help your Committee in its efforts to develop a comprehensive, community-based mental health system for American Indians and Alaska Natives. OTA will undertake this task as part of its new study on adolescent health, the request for which asked us to include the problems of American Indians and Alaska Natives. As we discussed with you previously, we will deliver a special report on the topic of the mental health of American Indian and Alaska Native adolescents by February 1989. Options for Congressional consideration will be included.

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Table 1

Fifteen Leading Causes of Death and Age-Adjusted Death Rates[a] Ranked[b] for U. S. All Races 1981 and IHS Areas 1980-82 (rate per 100,000 population)

Cause	U.S. (rank) (rate)	All IHS areas (excluding California)[c] (rank) (rate)	Ratio American Indian to U.S. All Races
Diseases of the heart	1 195.0	1 166.7	0.9
Malignant Neoplasms	2 131.6	3 88.5	0.7
Cerebrovascular disease	3 38.1	5 33.6	0.9
Accidents/adverse effects	4 39.8	2 136.3	3.4
Chronic pulmonary disease	5 16.3	13 9.5	0.6
Pneumonia/influenza	6 12.3	6 26.6	2.2
Diabetes Mellitus	7 9.8	7 27.8	2.8
Liver disease/cirrhosis	8 11.4	4 48.1	4.2
Atherosclerosis	9 5.2	-[d] 3.3	0.6
Suicide	10 11.5	9 19.5	1.7
Homicide and legal intervention	11 10.4	8 21.2	2.0
Conditions arising in perinatal period	12 9.2	10 9.8	1.1
Nephritis, et al	13 4.5	11 12.4	2.8
Congenital anomalies	14 5.8	12 6.5	1.1
Septicemia	15 2.9	14 6.5	2.2
Tuberculosis	-[d] 0.6	15 4.2	7.0
All others	- 63.8	- 150.8	2.4
All causes	- 568.2	- 778.3	1.4

[a] Both sexes combined.
[b] Ranked by number of deaths in order to be consistent with NCHS methods. Order by age-adjusted mortality rates may be different.
[c] Valid rates not available.
[d] Not among 15 leading causes of death.

SOURCES: U.S. all races: Department of Health and Human Services, Public Health Service, National Center for Health Statistics, Monthly Vital Statistics Report 33(3):supp., June 22, 1984; IHS Areas: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Indian Health Service, computer tape supplied to the Office of Technology Assessment, Washington, D.C., 1985.

Table 2

Leading Causes of Death and Age-Specific Death Rates
for Age Group 15 to 24 Years Old
U. S. All Races 1981 and IHS Areas 1980-82
(rate per 100,000 population)

Cause	Death Rate for Age Group 15-24 Years Old U. S. All Races 1981	IHS Areas 1980-1982[a]	Ratio American Indian to U.S. All Races
Accidents and Adverse Events	58.2	164.2	2.8
Suicide	12.3	38.2	3.2
Homicide	13.7	28.3	2.1
All Causes	101.0	142.2	1.4

[a] It should be kept in mind that these are average rates, and there is considerable variation among Indian tribes and service areas. In the Aberdeen service area, for example, the suicide rate among Indians between 15 and 24 is 4.8 times that of the U. S. all races population.

Testimony to the U.S. Senate Select Committee on Indian Affairs

by

Stephen A. Somers, Ph.D.
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Princeton, New Jersey

Mr. Chairman, thank you for inviting a representative of The Robert Wood Johnson Foundation to testify today on innovative programs in Indian health and mental health. My name is Stephen Somers. I am a Senior Program Officer at the Foundation and I am here on behalf of its President, Dr. Leighton E. Cluff, and my colleague, Ms. Annie Lee Shuster, both of whom are determined to find appropriate ways for us to contribute in this area. Indeed, Ms. Shuster is responsible for three (3) of the specific projects I will discuss today. I have primary responsibility for several broader national programs in which mental health services are being provided to urban Indians. We are hopeful that this hearing will be an important opportunity for all of us to learn about innovations sponsored by government agencies and other private sector organizations.

Before I describe our programs to you, perhaps I should say a word or two about The Robert Wood Johnson Foundation. For the record, an Annual Report, a copy of our proposal guidelines, and a recent statement of the Foundation's mission from Dr. Cluff are available for your staff. We are a health care foundation and have, since our inception as a national institution in 1972, made grants totaling more than $865 million. The majority of the grants have been for health service demonstration programs. But significant funding has also been devoted to training and health services research.

Up until the early 1980s, the rationale underlying many of our demonstration programs was to design and implement new models, evaluate them properly, and, if successful, disseminate them for broader replication by the federal government and others in the public sector. For example, we supported some early work on the hospice model, emergency medical services, and HMOs.

Today, however, it is clear that we can no longer rely solely upon public funding for the broader implementation of important social service initiatives. The federal deficit and competition from equally pressing social needs have compelled us to consider other means for beginning to address problems such as gaps in our nation's system of mental health services. Where possible, we attempt to design demonstration programs that: (a) build upon the current system's strengths and respond to specific gaps in that system; and (b) leverage other resources to help assure that available public funds for specific health services are targeted to those most in need. The programs I am going to discuss today all strive to meet these objectives.

First, I would like to describe the two broad national programs that touch upon the problem of Indian mental health. The Health Care for the Homeless Program is a nineteen (19) city program designed to establish primary health services for the urban homeless. Ironically, this is the one instance in the 1980s where the federal government did adapt and expand upon one of our models, in this case, through title VI (Health Care for the

Homeless) of the Stewart B. McKinney Homeless Assistance Act (HR 558). Several of the sites, particularly Seattle, Albuquerque, and Phoenix are serving significant numbers of homeless Indians. The program in Seattle has, in fact, formed a collaborative relationship with the Indian Health Board and has, as well, an alcohol counselor in the downtown emergency shelter who is arranging treatment for many Indians. In Albuquerque, mental health counseling, case management, and substance abuse counseling components have been added to a program which has served between 700 and 800 Native Americans.

Another very relevant national initiative is our nine-city Program for the Chronically Mentally Ill, which has as its goal the establishment of city-wide systems of care for the severely mentally disabled. Two of the projects, in Denver and Honolulu, are involved in special efforts to serve Native Americans with mental illnesses.

Of particular interest to you, Mr. Chairman, might be work being done with the Waianae Clinic under the direction of Ms. Alma Takata. The rural native population of that region needs culturally sensitive programming and has a particularly high rate (60-70 percent) of dual diagnosis (mental illness and substance abuse). Ms. Takata has been able to use The Robert Wood Johnson Foundation's grant funds to contract with this private clinic to develop special services that would not be feasible under the public mental health system because of regulations and union resistance. She is also working in the Diamond Head area where urban stresses present an entirely different set of problems for native Hawaiians with mental illnesses.

After years of exploring how the Foundation might support specific programs to improve the health and health care of America's native populations, we may finally be on the verge of making a major program announcement. Our systematic analyses and sessions with Indian leaders on the problems of American Indians and Alaska Natives, have educated us about the complexities of the health problems as well as the intricacies of the responsibilities of government and of Native Americans in their health care. Until now, we have not been able to settle upon an appropriate strategy for large scale Foundation investments.

Before describing that program, I would like to mention several single-site grants the Foundation has made over the last several years. In the area of Indian mental health, under the Foundation's Mental Health Services Development Program, a grant was awarded to the Providence Health Care Foundation of Anchorage, Alaska, to provide mental health training to 36 nurses in rural Alaska communities. The incidence of mental health problems is increasing rapidly in these areas and this program will seek to provide treatment to clients in their communities and general hospitals rather than admitting them to the one state mental hospital in Anchorage, Alaska, the Alaska Psychiatric Institute, which is not only more expensive, but also takes them away from their families and familiar surroundings.

We are also collaborating with the Henry J. Kaiser Family Foundation in its community-based health promotion and disease prevention program. One of the projects receiving RWJF funds is the Fremont Counseling Service in Lander, Wyoming, a community-based substance abuse prevention program targeted at Arapahoe and Shoshone adolescents on the Wind River Reservation in central Wyoming. The project's principal objectives are: (1) to reduce substance abuse rates among adolescents (under age 24); and (2) to reduce by 10 percent alcohol and drug-related incidents such as motor vehicle accidents, suicide, homicide, domestic violence, and fetal alcohol syndrome. Strategies include establishment of a Family Resource Center, a school-based substance abuse prevention curriculum, school-based peer support groups, and the development of drug-free activities for youth.

Later this month, the Trustees of the Foundation will consider the possibility of a Program to Improve the Health of American Indians and Alaska Natives, which could provide up to $6 million for grants over the next three years. The Program would encourage tribes and organizations serving significant numbers of Indian people to address the damaging health behaviors which result in high rates of Indian mortality and morbidity.

Specifically, in 1984, the age-adjusted mortality rates for Indian people in reservation states were considerably higher than those for the U.S. in general for the following causes:

(1) Alcoholism — 384 percent greater.

(2) Tuberculosis — 260 percent greater.

(3) Accidents - 132 percent greater.

(4) Diabetes Mellitus — 117 percent greater.

(5) Homicide — 73 percent greater.

(6) Pneumonia and Influenza — 51 percent greater.

In addition, of all American Indian and Alaska Native people who died during 1982-1984, 34 percent were under age 45, compared with 9 percent for the general population. The age-specific death rate for Native Americans was approximately two times that of the U.S. general population for age groups 15 through 44. These are mortality statistics and, as such, do not begin to convey the burden of illness or morbidity due to many of these chronic diseases. According to the National Center on American Indian Mental Health Research, reliable data on the incidence of severe mental disorders are not available. Indeed, most of the data cited above are not applicable to all Indian groups. The wide heterogeneity among tribes and settings is reflected in wide ranges in the mortality and morbidity rates.

The high mortality rates in the under 44 age group and the nature of the causes of death make this group a major focus of any effort to impact upon the health of Indian people. The causes are damaging health behavior and, as such, appropriate interventions need to be identified and implemented to break this cycle of excessive morbidity and mortality. In large measure, these early deaths are preventable and the significant morbidity associated with accidents and chronic diseases can be modified through targeted prevention programs. Giving Indian communities the capacity to design and initiate their own preventive efforts may lead to reductions in pervasive damaging health behaviors. One of the areas in which the Robert Wood Johnson Foundation might make a contribution is the design, implementation, and evaluation of culturally sensitive mental health services for Native Americans.

In addition to projects focused on prevention of damaging health behaviors outlined above, the Foundation's Program to Improve the Health of American Indians and Alaska Natives would encourage proposals in two other areas: (1) projects focused on improved care for infants, children and adolescents, and the elderly; and (2) projects focused on enhancing the management of health services by Indian people.

It should be noted that Foundation support for projects in this Program would not be used to duplicate or replace services or activities funded by the Indian Health Service or other sources.

The Foundation is very pleased, Mr. Chairman, to be invited to participate in the early stages of the Select Committee's consideration of initiatives to help the Indian people as they develop their own health improvement strategies.

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Sources: Indian Health Service Chart Series Book, April 1987.
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American
Psychological
Association

Advancing psychology as a science, a profession, and as a means of promoting human welfare

TESTIMONY OF

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Offered by

Diane J. Willis, Ph.D.
Director, Psychological Services
Child Study Center, Department of Pediatrics
University of Oklahoma

before the

SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

on the subject of

AMERICAN INDIAN AND ALASKAN NATIVE CHILDREN'S MENTAL HEALTH

July 7, 1988

The Honorable Daniel Inouye, Chair

7/7/88

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The American Psychological Association (APA), on behalf of our 90,000 members, is pleased to present this statement as part of the hearing record of the Senate Select Committee on Indian Affairs. We commend Mr. Inouye and other members of the committee for their commitment to addressing the issue of mental health for American Indian and Alaskan Native children. We hope to present you with information on the mental health status of the American Indian and Alaskan Native. Once these statistics and issues are conveyed, we will then make recommendations that attempt to rectify the deficits in service delivery.

I am Diane J. Willis, Ph.D., Director of Psychological Services at the Child Study Center in the Department of Pediatrics, University of Oklahoma Health Sciences Center. I am of Kiowa descent and a voting member of the Kiowa Tribe in Oklahoma. My practice includes assesment and/or treatment of children and families, including Indians, who have developmental problems or who are the victims of child abuse. I have been and continue to be a consultant to various tribes on a variety of issues, particularly on child abuse assessment, prevention, treatment.

Health Status of American Indians and Alaskan Natives

According to the 1980 U.S. Census, there are approximately 1.4 million American Indians and Alaskan Natives in this country. The median age is 20.4 for American Indians and 17.9 for Alaskan Natives compared with the median for the general U.S. population of 30.3 years. This median age is lower since American Indians die younger and face greater health problems than any other race. For example, Indians die from diabetes at a 117% greater rate, tuberculosis at a 280% greater rate, and pneumonia and influenza at a 51% greater rate than all other races.

Another medical problem among American Indian children is "otitis media" (middle ear infection). Seventy-five (75%) of Indian pre-schoolers suffer from this infection. Gone untreated, otitis media can lead to permanent hearing lost, attention problems, language and cognitive difficulties, or other disciplinary and learning problems. An additional deterrent to successful education is neurological problems in Indian children. Thirty-eight percent of those in Bureau of Indian Affairs' school are physically handicapped through central nervous system damage. Many of these resulted from poor nutrition during pregnancy.

The leading causes of death among the American Indians in the age range 1 to 14 years are accidents and homicides, while statistics show that accidents and malignant neoplasms are the leading causes of death in all other races. Indians in the age range 15 to 24 years die at a greater rate from accidents compared to that for all other races in the same age range. The fact that American Indians die from accidents at a rate that is 132% higher than the rate for all other U.S. races can likely be attributed, at least in part, to the high alcoholism problem.

Alcohol and drug abuse has been seen as a major problem in adult Indians for years. Only recently has it been viewed as a child and adolescent problem. Fifty-two percent of urban Indian adolescents and 80% of reservation Indian adolescents engage in moderate to heavy alcohol or drug use as compared to 23% of their urban non-Indian counterparts. Children as young as four years of age can be found drinking and using inhalants.

Delinquency and arrest rates of American Indians are among the highest of any ethnic minority group in the U.S. (U.S. Dept of Justice, 1976). Over five times as many American Indians as Whites are likely to be in correctional institutions (U.S. Census, 1980). The alarming rate of Indian suicide is also cause for much concern. The rate is 1.7 times higher than for all U.S. races--14.23 per 100,000. The rate for school-aged Indian children alone is three times greater than that of the American White majority (U.S. Congress, Office of Technology Assessment, 1986).

Sociopsychological and Economic Stressors

Statistics show American Indians at the lowest end of the socioeconomic scale. They suffer higher unemployment than all other races. It hovers at about 30% on most reservations and ranges from a high of over 70% on some plains reservations to a low of 20% in the case of more prosperous tribes (U.S. Senate Select Committee on Indian Affair, 1985).

In addition, the Indian population lags behind all races with respect to education. The average years of formal education is 9.6, which is below the national mean of 10.9 years. Nearly one-third of all American Indian adults are classified as illiterate, and only one in five men has a high school education. Dropout rates between the eighth and ninth grades in some urban areas range from 48% to 85% and approach 50% in Bureau of Indian Affairs boarding schools and day schools on the reservation. Only 16% of the American Indian students who enter universities complete an undergraduate degree compared to 34% of their White counterparts.

A problem that has been of considerable concern for Indian children is the high rates of institutionalization and out-of-home placement or adoption of Indian children by non-Indians. Despite the passage of the Indian Child Welfare Act in 1978, that prevents or decreases the number of out-of-home placements for Indian children, a recent Children's Bureau report noted that children in state care rose 12% from 1982 to 1984 and Bureau of Indian Affairs (BIA) out-of-home care increased 24% from 1983 to 1985. The 1980 Census revealed that there were 55,000 Indian children under 18 years of age in government boarding schools, youth job training facilities (e.g., Job Corps), and/or as permanent residents in state hospitals or other forms of state-supported institutions. Seventy-five percent (75%) of the American Indian children in boarding schools experience some type of emotional problems. Those placed in foster care with non-Indian families are suffering at a rate of approximately 25%-35%. Thus, the Indian community is quite concerned about the destruction of the Indian family, the loss of transmission of the Indian culture to the next generation and the emotional problems that stem from these.

Mental Health Status

The aforementioned problems, and more, contribute to the stressors in the lives of American Indian and Alaskan Natives mental health. These stressors are affecting the mental health of the children. It is estimated that between 20-25% of Indian and Alaskan Native children suffer emotional disorders compared with 5-15% of Anglo children. Among the emotional problems identified are child abuse, neglect, depression, alcohol abuse, school behavioral problems and suicide attempts.

The manifestation of the mental health problems among Indians is inextricably linked to the conflict between the traditional culture and the one forced upon this indigenous group, and the consequences attached to being an oppressed group in the U.S. "Poverty, cultural destruction, massive social change, and feelings of social injustices and mistrust aris[e] from a history of victimization and genocide" (Miller, 1983). Psychologists have shown a strong correlation between certain types of self-destructive behavior, i.e., alcoholism and suicide, and the state of hopelessness and powerlessness.

Mental Health Services

Exacerbating this problem is the non-availability of adequate mental health services. The largest single provider of mental health services to American Indians is the Indian Health Services (IHS). More than 750,000 urban and rural American Indians utilize direct care or contract services of IHS. In 1985, the IHS budget mental health budget was $10,518,000 and the alcoholism budget was $24 million. These two categories accounted for 7.3% of the total Indian Health Services (IHS) budget allocations for direct and contract services. However, these services cover only crisis intervention and emergency care. If the Indian Health Care Improvement Act is authorized, it would expand services to include prevention and rehabilitative interventions.

Another provider of mental health services to American Indians is the Department of Interior's Bureau of Indian Affairs (BIA). Twelve geographic areas are served by 123 offices. These offices reach 281 tribes which total approximately 649,000 people. Psychological services are provided through the educational and social service branches. The educational branch provides services through educational programs. The social services branch provides child welfare and family services, including help with problems from family disintegration and emotional instability.

Mental Health Service Providers

These mental health services are primarily delivered by paraprofessionals and social workers. This absence of psychologists is two-fold. One, many American Indian mental health services programs (IHS, BIA, etc.) feel that the hiring of other health professionals is more important than mental health professionals (although 60-70% of the U.S. general population's medical office visits are psychological in nature rather than physical). Two, there is a lack of trained professionals who are sensitive to American Indian culture. In 1976, there was only one psychologist of any ethnic background for every 43,000 American Indian people (Welch, 1976). A 1985 survey, by the American Psychological Association (Stapp et al, 1985) reported 180 American Indians held masters or Ph.D.s in psychology. This number boosts the personnel rate to one American Indian psychologist for every 8,333 Indian people. Though better than 1976, it is a poor showing compared to the general population ratio of therapists to clients of 1:

2,213. It must also be pointed out, however, that the 180 figure is a combination of all masters and doctorates in different specialties within psychology. Thus, 102 are researchers and 36 in educational services. Forty-two therapists remain, though some of the 138 researchers and educators have some involvement in mental health delivery. Therefore, the underrepresentation that still exists among American Indian psychologists is of serious concern.

A significant increase of American Indian psychologists may not occur in the future due to the lack of professional role models and so few psychologists that serve American Indians on Indian reservations. A few scholarship/fellowship programs exist to help alleviate this dearth. For example there are the NIMH Minority Fellow Programs that exist in such organizations as the American Psychological Association and the American Psychiatric Association. There is also the Indian Health Scholarship Program that has just begun accepting applications for students wishing to pursue counseling psychology as a specialty. Each of these programs has a handful of American Indian students. It will take much more to aid the deficit of American Indian mental health professionals.

Another option of service delivery for the American Indians is community-based services. American Indian tribes residing on reservations were empowered with freedom to design a wide range of services, including mental health care, through the Indian Self-Determination and Education Assistance Act of 1975 (PL 93-638). To date, 61 different tribal health programs have been established under contract to the Indian Health Service, but fewer than half of these programs have mental health components.

The use of traditional healers who both help and heal still remains the leading mode of therapy in several tribally based communities. As such, American Indian communities both on and off the reservations have traditionally practiced informal caregiving through the extended family. For example, in "network therapy" the focus of help giving is to mobilize the family, relatives, and friends into a socially interdependent force that can be attentive and responsive to emotional distress within the family in order to counteract the depersonalizing atmosphere of urban life.

There is another alternative approach to mental health services in the American Indian community. It is possible for modern psychotherapists to integrate some traditional understanding of mental illness (biological and environmental) with traditional cultural healing practices. In fact, American Indian clients experience little, if any, conflict about integrating both traditional and modern psychological approaches (Meyer, 1974). Thus, it seems that psychologists are more reluctant than the clients to this change. Ethnic psychologists in the United States, however, have begun to stress the need for adjusting therapeutic interventions to fit the client (Sue, 1977) since inappropriate therapy and the imposing of ones values/views can be more harmful than helpful.

Western psychological theory may not be appropriate for American Indian culture. Many well-intentioned psychologists believe that they could best help American Indians by helping them adjust to Western value systems or create a more personal value system of their own. Many American Indians who engage individual therapy often express concern that this conventional

Western psychology superimposes biases onto American Indian problems and shapes the behavior of the client into a direction that conflicts with Indian cultural life-style orientations and values. Individual, ego-based therapy is incongruent with the American Indian way of life. Mental health problems, as believed by many American Indians, is due to excesses ego-based thoughts and actions (greed, envy, etc.). Thus tradition Western therapy is inappropriate for this belief system. Instead, the American Indian culture feels the person with mental illness must restore the good graces of family, tribe and the spirit world through confession and atonement.

Conclusion

Thus, it appears that much is needed in mental health research and service delivery of American Indians. American Indian children are suffering at a higher rate than any other group in the U.S. population. Alcoholism, drug abuse, suicide, family deterioration, mental illness, crime, etc. are all by-products affecting the young people of this displaced native group. In a society where there are political or financial "minorities", such problems will continue to exist in these groups. Since this is a reality in the United States, adequate medical and psychological care must be awarded and promoted for minority groups such as the indigenous American Indian and Alaskan Native.

An active role by the U.S. government and the profession of psychology itself in promoting adequate mental health services or health maintenance activities for these groups is needed.

Recommendations

The Senate Select Committee on Indian Affairs has been very responsive in the past and I would like to express appreciation on behalf of the American Indian and Alaskan Native community. The following recommendations are to aid the Committee in their future discussions and deliberations.

1. **Program Diversity.** The differences between urban and reservation Indians should be taken into account when making decisions regarding programs. The geographical isolation of the reservation creates problems for the rural Indian. Problems include difficulty in accessing resources outside the reservation, lack of intellectual and personal stimulation, powerlessness, poverty, lack of education, lack of role models, joblessness and lack of economic opportunities. Programs that replenish self-determination and power, that teach economic management, that introduce role models and that stimulate the value of education are highly recommended.

The urban Indians also have particular problems that need to be addressed. The problems associated with physical isolation may not be acting as much as the emotional and professional isolation within the city. Programs for urban Indians may need special emphasis on coping mechanisms for discrimination and incentives for education.

2. **Education.** There is a need to improve the education level of American Indians. Most Americans are aware of the power that a formal education holds in economic and intellectual success. Many ethnic minorities in the U.S., however, have not had the opportunity to view the education-success

contingency. Even after successful pursuit of an education, however, many are deprived of the rewards that an education should provide. America must ensure appropriate rewards for education. The result will be improved motivation for educational pursuits.

Improving the educational system from the first day of school is a good beginning. It is difficult to find teachers to come to the reservations but there should be no compromising when it comes to young, formative minds; therefore teachers must be credentialed. The hiring of teachers certified in learning disabilities and reading disorders is also recommended. In addition, educating American Indians will enable them to return to their own community to provide services. Monies need to be allocated for scholarships and fellowships to encourage the pursuit of higher degrees. Presently, as stated earlier, NIMH and the Indian Health Scholarship Program has funds for students pursuing doctorate degrees. Again, only a handful of American Indians are enrolled in doctorate programs. We would like to recommend that monies be allocated for those enrolled in terminal masters programs. A payback program may be needed to ensure service to the American Indian population. The hiring of special education teachers is also recommended.

Until the time when these graduate students will be serving their communities, a "stopgap" measure may be needed. There are many elders, healers and community leaders who could be trained as paraprofessional mental health workers. Internship/practicuum programs, affiliated with universities or mental health centers, may be a way to educate these already established service providers. Funds will be needed to design and implement such programs.

4. **Public Education**. This emphasis on education must begin early. We suggest programs involving families in a comprehensive educational program. It can begin with parents being educated about nutrition, parenting, intellectual stimulation, child abuse, etc. These programs will open the way to courses on mental health awareness, alcoholism, substance abuse, prevention, etc. Other adult incentives should include courses on financial and business management (land and business procurement, marketing, production, small business loans, etc.)

5. **Health**. The aforementioned issue of untreated cases of otitis media emphasizes the need for simple regular medical check-up of American Indian children. Mandatory hearing tests would detect this problem immediately. Lack of prenatal care was mentioned as a major cause of neurological problems among Indian children. In addition to on-going health care programs, a more aggressive prenatal program is very much warranted. Within IHS, we must target mental health positions, especially child mental health, so that psychologists/psychiatrists will be hired to provide services to children and families.

6. **Legislation**. We recommend the passage of legislation regarding the quality of mental health services to the Indian community. Since inappropriate services can be worse than no service, it is important that service delivery be regulated. It is important to have service providers who have knowledge and sensitivity of the American Indian culture. Therefore, we recommend that specific mental health positions be designated for professionals or paraprofessionals of Indian decent or who have been

shown to have a commitment and sensitivity to the American Indian population. These designated positions can be in existing community mental health centers. Also, challenge grants can be established for centers to target services to the American Indian.

Another legislative action that needs to be taken is the tightening up of the Indian Child Welfare Act. As with the majority culture, many laws are difficult to enforce. However, the Indian Child Welfare Act, outlining child abuse investigations, is a "tribal nightmare". Investigations are not proceeding as they should and more stringent guidelines need to be incorporated. In addition, legislation should be made to penalize areas that do not keep adequate records on neglect and child abuse. The tribes need to know that government is serious about protecting children and preventing child abuse.

Finally, monies for research, especially prevention or health/mental health research is needed. We need to adapt or develop alcohol, drug, and abuse prevention programs for use at the elementary or high school level for students living on reservation lands or in urban areas, and educational programs for parents need to be developed. We need to research tough issues such as ways to increase utilization of mental health services or the efficacy of certain treatment programs for Indian children and their parents. We need to study the process of health decision-making among Indian adolescents and why they seem to lack efficient decision-making skills. We need to study ways of developing programs to enhance the Indian child's language skills or his/her science and math skills. The problems of cultural bias in testing of Indian children who are having academic problems needs to be remedied and we need to learn how to get around these biases to better understand the strengths as well as the problem areas in the learning style of Indian children.

In closing, the American Psychological Association strongly supports the efforts of the Senate Select Committee on Indian Affairs to improve the mental health status of American Indian and Alaskan Native children. We commend Chairman Inouye and the members of the Committee for their attention and commitment to addressing this very serious national problem. The American Psychological Association appreciates this opportunity to express our views, and we look forward to continued work with the Committee. I will be happy to respond to any questions that the Committee may have.

STATEMENT

of the

ASSOCIATION OF AMERICAN INDIAN PHYSICIANS

on

COMMUNITY BASED MENTAL HEALTH SERVICES FOR AMERICAN INDIANS/ALASKA NATIVES

Presented by

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Before the

SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

July 7, 1988

Mr. Chairman and members of the Committee, I am Dr. James Thompson, Associate Professor of Psychiatry, University of Maryland, speaking for the Association of American Indian Physicians (AAIP), of which I am a long time member. The AAIP is a professional medical society made up of physicians who are American Indian or Alaska Native. I am pleased to appear before the Committee to represent the concerns and viewpoints of the AAIP regarding community based mental health care for Indian people.

Mr. Chairman, as you are well aware, significant advances have been made in the past few years in improving the health conditions for Native Americans. Nevertheless, an unacceptable gap still remains between the health status of Native Americans and that of the general U.S. population. Health conditions among Indian people have been likened to that of underdeveloped, Third World nations. Sadly, many of us who are familiar with Indian reservations and other Indian committees know that this is not an exaggeration. This second class health status is simply unacceptable in the United States today, a country that has longstanding legal and moral obligations to deal effectively with the health problems of its Native population.

Of particular concern in this second class health status are Indian mental health, alcohol and drug abuse-related problems. These problems are universally believed to be of epidemic proportions today among Indian people. Although Native Americans have experienced a significant improvement in the prevalence of infectious disease such as tuberculosis, the so-called social or behavioral causes of sickness and death have become much more prominent. For instance, deaths due to alcohol, accidents, homicide, and suicide are many times more common today among Indians than among the general U.S. population. In spite of these growing epidemics, however, adequate mental health and substance abuse services are still largely unavailable. In addition, although these problems are inseparable from general health problems, mental health, alcohol, and drug abuse programs are seldom effectively coordinated with general health programs.

Therefore, despite progress in solving some health care problems, many others still exist, and in fact may be getting worse. Major financial and manpower shortages in the Indian Health Service further aggravate the situation, and drastically interfere with the ability of the Indian Health Service (IHS) to accomplish its mission to elevate the health status of American Indian and Alaskan Native people to a level equal to that of the general U.S. population.

We are grateful to this Committee for its concern with improving the mental health status of Native Americans. We hope today to present some of our concerns and ideas to you concerning how such services could be improved, and we look forward to working with you over the next several months to make some of these ideas reality.

I would first like to offer some definitions of what terms such as "community based care" and "mental health" mean to the AAIP. We understand community based care to mean comprehensive, quality care, delivered in settings as close to the patient's home community as possible, and delivered in ways which are sensitive to the patient's culture and beliefs. We do not mean by this term to include only outpatient care, which is what is sometimes what is meant by "community mental health", but rather a broad range of services, including inpatient and outpatient treatment, day treatment, residential treatment, and other forms of care.

Also, we mean by the term "mental health care" the treatment of diagnosable mental disorder, including treatment for substance abuse. We do not mean care which is meant to improve to maintain emotional well-being in an otherwise well person. Improving emotional well-being is indeed a worthy goal, but should in our view not be funded in preference to funding the services needed to treat diagnosable mental disorder.

Nor by "mental health care" do we mean primary prevention -- that is, efforts to prevent the occurrence of mental disorder before any sign of the disorder is present. Again, this is a worthy goal, but primary prevention of proved effectiveness is rare throughout medicine, and is almost non-existent in psychiatry. Before primary prevention programs are begun, we believe that basic clinical services should be provided.

These clinical services can, and should, include secondary prevention -- the early recognition, referral, and treatment of persons with psychiatric disorders, and well as early intervention into clinical conditions which predispose to mental disorder. These clinical services can, and should, also include tertiary prevention -- the followup of previously ill persons to prevent the reoccurrence of illness.

We would like to stress four additional points today. First, we believe that in new and existing programs, the fragmentation of care which is now the norm must be corrected. Second, although we strongly support the concept of programs which are locally run by

Indian people, ways must be found to encourage such programs to work with other programs -- in the IHS, or in the non-Indian public or private sectors. Third, we would argue for an approach to mental health care for Indian people which is built on the needs of the patient, rather than on the ideology of the providers. And fourth, we feel that specific attention must be paid to the cultural relevance of services delivered to Indian people.

Definition of "Community Based Care"

As a psychiatrist with subspecialty training in community mental health, I am aware that over the years the meaning of "community based care" has diverged from its original conceptualization as presented in President Kennedy's message to Congress initiating the Community Mental Health Center (CMHC) legislation. Originally, the CMHCs were to be a part of general community hospitals, where, to use President Kennedy's words:

> "Private physicians, including general practitioners, psychiatrists, and other medical specialists, would all be able to participate directly and cooperatively in the work of the center. For the first time, a large proportion of our private practitioners will have the opportunity to treat their patients in a mental health facility served by an auxiliary professional staff that is directly and quickly available for outpatient and inpatient care." [Message from the President of the United States Relative to Mental Illness and Mental Retardation, 88th Congress, 1st session, U.S. House Document 58, Washington, DC, 1963]

Increasingly over the last two decades, however, community based mental health care has come to mean just outpatient care, or at best non-hospital based care. Although outpatient mental health services are indeed badly needed by Indian people, the AAIP would like to draw the Committee's attention towards an understanding of "community based" as comprehensive, quality care, delivered in settings as close to the patient's home community as possible, and delivered in ways which are sensitive to the patient's culture and beliefs. This includes not only outpatient care, but also a broad range of services, including inpatient and outpatient treatment, day treatment, residential treatment, psychosocial rehabilitation, and other forms of care.

Definition of Mental Health Care

Related to the above is the conceptualization of "mental health care". Again, much of the CMHC movement gradually redefined "mental health care" to mean the provision of counseling for the "worried well", brief followup for previously hospitalized chronically mentally ill persons, and education programs meant to prevent mental illness. Although clearly not uniformly the case in all CMHCs, at its worst this has meant centers in which therapists and counselors, often with little training, disappear into offices with "clients" who have little or no sign of mental disorder, and are simply unhappy or dissatisfied; "aftercare" clinics, where psychiatrists dole out prescriptions for schizophrenic patients whom they have seen briefly or not at all; and extensive efforts to educate school, church, and other community groups about mental illness, hoping that somehow this will prevent mental illness from occurring.

Mr. Chairman, I do not want to imply that all CMHC programs, or that all IHS mental health and alcoholism programs, are as I have described. Clearly there exist high quality Indian and non-Indian programs to treat persons with mental disorder. But anyone close to either CMHC or IHS programs can tell you that the scenario I have described is all too frequent.

Therefore, the AAIP wishes to present to the Committee our understanding of "mental health care" as the treatment of diagnosable mental disorder, including treatment for alcohol and drug abuse. We do not mean care which is meant only to improve or maintain emotional well-being in an otherwise well person. Improving emotional well-being is indeed a worthy goal, but should not in our view take precedence over providing the services needed to treat those with diagnosable mental disorder.

In addition, we do not include in our definition of "mental health care" the provision of services aimed at primary prevention -- that is, efforts to prevent the occurrence of mental disorder before any sign of the disorder is present. Again, this is a worthy goal, but primary prevention of proved effectiveness is rare throughout medicine, and is almost non-existent in psychiatry. We believe that if a choice must be made between basic clinical services and primary prevention programs (and we think that given available resources, this choice indeed must be made), the choice must be in favor of clinical service provision. These clinical services indeed can and should include secondary prevention -- that is, the early recognition, treatment, and referral of persons with psychiatric disorders (or persons with conditions which predispose to mental disorders). Clinical services also can and should include tertiary prevention -- that is, the followup of previously ill persons in order to prevent the reoccurrence of illness.

We also believe that the delivery of clinical services, must involve extensive face to face contact of the patient with practitioners highly trained in the care of mental disorder. Only with such contact is it possible to deliver the high quality of care for mental disorder which is now feasible. During the last few decades the ability to effectively treat the mentally disordered patient has grown dramatically. New diagnostic and assessment procedures, effective medications, psychosocial rehabilitation approaches, and targeted forms of psychotherapy are now available. We no longer must rely solely on supportive counseling of persons with mental disorder, as though this is all that we can do to help. To deny Indian people the benefits of the dramatic progress in psychiatry and the mental health related fields amounts to institutional malpractice. There must be renewed efforts to train and recruit high level professionals who can apply the fruits of this progress.

Fragmentation of Care

We believe that in new and existing programs, the fragmentation of care which is now the norm must be corrected. At present, there are in most Indian communities a general health program, a mental health program, an alcoholism program, and a social services program. These often have separate budgets, administrations, staffs, services, and ideologies. The attitude is more often one of competition for patients, rather that collaboration. This is in the face of mounting evidence of the high comorbidity between substance abuse and other mental disorders, and between these and general medical and social problems. Anyone who has treated Indian people can attest that these comorbidities are present in perhaps greater amounts than in non-Indians. For no other population is the need to coordinate services more obvious.

Neither should coordination stop with the formal services we have mentioned. Collaboration is also needed with groups and institutions such as schools, employers, tribal leadership, and with families. One answer you will undoubtably hear to the coordination problem is case management. In fact, the IHS, through the Community Health Representative program, has had case management for years. The AAIP is very supportive of this innovative and effective program. But case management is only effective when services are accessible, available, and are adequate in number and quality. And case management is only effective when the case manager has access to the power to assure cooperation between services. There are presently many organizational and political barriers which work against cooperation between general health, alcohol, mental health, and social service programs. Adding a case manager will be able to accomplish little unless these barriers are removed. An example of an attempt to remove such barriers is the Robert Wood Johnson demonstration projects to coordinate services for the chronically mentally ill. Such demonstrations might be taken as a model for collaboration between services for Indian people.

In coordinating services we must not forget the primary care physician, who not only is in an excellent position to help in early recognition of mental disorder, as well as in referral and treatment, but in addition is well placed to help coordinate community institutions and services, thereby building a care-giving network or system for Indian patients.

Another suggestion for improving coordination is to form a peer review process which would be charged in part with assessing coordination. If the process was designed to cross service area lines, this might also serve as a mechanism for programs to learn from others about coordination and other aspects of services delivery.

Encouraging Tribal/non-Tribal cooperation

Related to the need for program coordination, is the separation which often exists between tribally run programs, IHS programs, and non-Indian programs which Indian people utilize. Although we strongly support the concept of programs which are locally run by Indian people, ways must be found to encourage such programs to work with other programs, and vice versa. These incentives might be administrative, financial, or political. For example, programs which collaborate with others might receive bonus payments which they could use to improve services. Such financial incentives have been effective in several states in encouraging the treatment of patients in the community, rather than in distant state mental hospitals. The same principle could be applied to encouraging program collaboration in the care of Indian patients. Also, the Robert Wood demonstration cities, mentioned above, could be surveyed to discover what innovations in service collaboration might be transferred to the care of Indian people.

There are also examples of collaboration in Indian country which might be taken as models and generalized. One is in Anadarko, Oklahoma, at the Riverside School, an off-reservation boarding school. Riverside, along with the IHS, is contracting with a hospital-based behavior medicine unit in Oklahoma City to provide alcohol and drug abuse treatment for students, education for school staff, and counseling for high risk students.

The Needs of the Patient as Primary

We would argue for an approach to mental health care for Indian people which is built on the needs of the patient, rather than on the ideology of the providers. I have already mentioned some of the mistakes of the Community Mental Health movement. Yet another is the strong tendency of that movement to operate on ideology, rather than on what is best for the individual patient. Any discussion of community based mental health care is bound to be filled with discussions of educational models, social models, medical models, alternative services models, and human service models. Mental healthers spend a great deal of time and energy defining and adhering to their ideological model -- so much time and energy that the recipient of services is in effect forgotten. What becomes all important is fitting each patient into the ideological framework of the provider, rather than individually assessing and treating each patient. Substance abuse treatment is also filled with those who believe that their ideology represents the one "true" way, often at the expense of the needs of the individual patient.

We would argue for services which do individually assess and treat each patient, in an atmosphere as free from ideology as is possible. In a case management program with which I am associated in the City of Baltimore, we have developed an example of a program which is to a great extent "beyond ideology". A diverse group of professionals works to discover as many avenues as possible to help the mentally disordered individual. Some of these avenues are quite traditional, and others non-traditional. But these are all keyed to what the recipient of services needs at a given point in time in order to improve symptomatically or functionally. I might add that this approach is similar to an ideal of the community mental health movement -- the use of the therapeutic team -- which unfortunately has rarely become a reality in community mental health practice.

Operating out of ideology has another pitfall. Providers who practice based on their belief system, rather than on the needs of the patient, do not see the need for research and evaluation to test the effectiveness of their interventions. They simply "know" that they are doing the right thing. Because of this, the CMHCs, and other programs such as the NIMH Community Support Program, have seldom been dispassionately evaluated or researched. We don't know whether or not they are effective at all, or if they are, which parts of the program are effective for what patient groups.

We therefore hope that any plan formulated by this Committee is not based on a narrow ideology, but is based on an approach which does not rule out any approach which may be of benefit to the recipients of care, and which lends itself to evaluation and research to determine its effectiveness.

Culturally Relevant Services

Finally, we feel that specific attention must be paid to the cultural relevance of services delivered to Indian people. This is a precept which is often stated, but is seldom applied in a systematic way. There are, however, specific steps which can be taken to move towards cultural relevance. We suggest that a minimum group of steps is (1) the involvement the tribes, tribal elders, and indigenous healers in planning and evaluating programs; (2) provision of cultural education for mental health professionals in a program which begins before they start to deliver services. This may be necessary even if the professionals are themselves Native Americans, if they are not from the area being served; (3) form a peer review process which will look at quality and appropriateness of care from a cultural point of view.

We believe that cultural relevance can be achieved in approaches which combine western medicine with traditional culture and values, utilizing the best from each tradition. Programs do not have to choose to between a totally white or totally Indian approach, although the care for a particular patient might well be one of western medicine, traditional Indian medicine, or a combination of both.

Conclusion

Mr. Chairman, thank you for your efforts to address the tremendous unmet health needs of American Indian and Alaskan Native people by supporting the development of programs, resources, and facilities necessary to deliver effective care. We know that the decisions to be faced in order to revamp the mental health care delivered to Indian people will not be easy ones. But we stand ready to work with you in dealing with these difficult issues, because of the great need to improve the care for Indian people who suffer from mental disorder and substance abuse.

And thank you for allowing us the opportunity to testify before your Committee.

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STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

ON

COMMUNITY BASED MENTAL HEALTH SERVICES FOR
AMERICAN INDIANS AND ALASKA NATIVES

PRESENTED BY

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BEFORE THE

SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

JULY 7, 1988

Mr. Chairman and members of the Committee, I am Dr. Linda Kames Cross, Assistant Professor of Psychiatry, Michigan State University, and chair of the Committee of American Indian and Alaska Native Psychiatrists of the American Psychiatric Association, a medical specialty society representing more than 34,000 psychiatrists nationwide. I am pleased to appear before this Committee to represent the concerns of the American Psychiatric Association regarding community based mental health care for Indian people.

Trying to summarize Indian mental health issues and make concrete, constructive suggestions for improvement is a rather overwhelming task. It is difficult to separate mental health issues from the many enviornmental factors adversely affecting the quality of life for American Indians today. These of course include the socioeconomic problems of poverty and unemployment, the high dropout rate for high school and college students, and the widespread prevalence of alcoholism and substance abuse.

It is also difficult to separate mental health problems from other health problems. Over 50% of office visits to family doctors are for problems with a psychiatric basis or concomitant. Alcohol is a major factor in the high incidence of Indian deaths from accidents (3.4 times the national average), suicide (1.7 times the national average), and homicide (2.0 times the national average). One can only guess at the enormous health care costs for survivors of accidents, suicide and homicide attempts, as well as physical complications of chronic alcoholism. It's a matter of "pay now or pay later," and with the crisis-oriented approach necessitated by chronic underfunding of mental health and substance abuse treatment (not just in the Indian Health Service but in the country as a whole), we unfortunately will never know how much money could be saved in other health care costs if adequate mental health care were available to everyone.

With the ongoing shift of the population toward urban and other non-reservation areas, our sense of identity as Indians is also changing. Over half of the Indians in the United States now live in urban areas, and almost two-thirds live off the reservations. Where Indians live together in communities, mental health problems often reflect community problems. However, social isolation tends to be a problem for those Indians who are not a part of the Indian community. They are often caught "between two worlds" and feel that they don't fit in anywhere. Or they may decide to acculturate totally and stop identifying themselves as Indians. This is their loss as well as ours. Fifty percent of the Indian population today is 18 or under. They need role models of Indian people who have successfully adapted to our changing society while maintaining a sense of their Indian identity and a pride in their heritage. This is somewhat of a philosophical matter, but I think it needs to be taken into account as we look toward the future and set long-range goals for ourselves as a people. Until our society as a whole — and this requires leadership by the highest levels of government, including our President — recognizes that we are citizens, and appreciates our differences rather than trying to obliterate them, specifically Indian programs are necessary and should be supported. They provide an answer to the social isolation and loss of culture that affect so many young Indians today — and older ones, too, for that matter. We need programs that bring the elders together with the young, so that what is left of our culture can be passed on. We need strong support systems for our Indian college students, who are often homesick and unfamiliar with "the system," and easily get lost in the crowd. And we need mental health programs for urban and non-reservation Indians just as much as we need them on reservations.

Sometimes we are our own worst enemies. Inter- and intra-tribal politics often result in competition where there should be cooperation. I am a strong believer in self-determination, but the growing pains are agonizing. There is still much evidence of what I call a "victim mentality" — an attitude of "learned helplessness" that results from having been victimized. Many of our people today are victims — the incidence of abuse is high — but it is also our heritage. After being so long dependent on the Federal government, there is a common attitude that "they owe us," which may result in nepotism and downright corruption in Indian-run programs, with the few Federal dollars available to us not being used in the most effective manner and benefiting the people who need them most. This is our problem, not yours, but we need your help by enforcing accountability in Indian-run programs to not only ensure this does not occur but also ensure that nepotism and corruption will not be counteranced. With these preliminary statements of the way, there are five major points that I would like to raise:

1. Inadequate funding of mental health programs in general results in a crisis-oriented, bandaid approach to pervasive mental health problems which cannot be improved without community intervention efforts.

2. The inadequate numbers of professional mental health workers in the Indian Health Service results in the majority of patients (even those with serious psychiatric disorders) being treated by paraprofessionals, with minimal supervision of not only psychiatrists and other physicians but also by psychologists.

3. The fragmentation between substance abuse treatment and other mental

health services leads to inefficiency and ineffectiveness.

4. Existing community mental health services are underutilized. For the most part this is because of a lack of awareness of and sensitivity to Indian cultural differences, including a lack of effort to coordinate with Indian tribal resources and referral sources.

5. Problems of jurisdiction arise with Indians on reservations who are in need of civil commitment to State institutions.

1. Inadequate funding of mental health programs in general results in a crisis-oriented, bandaid approach to pervasive mental health problems which cannot be improved without community intervention and prevention efforts. I don't need to elaborate much on this. I just want to emphasize that alcoholism and its effects are community problems and will not go away until communities band together to face this problem and do something about it. Yes, we need treatment programs, but we need treatment programs that involve the patients' families, extended families, and utilize community resources. We need psychotherapy for the pervasive psychological issues that arise from growing up in a dysfunctional family. This leads to my second point:

2. The inadequate number of professional mental health workers in the Indian Health Service and many Indian mental health programs results in the majority of patients (even those with serious psychiatric disorders) being treated by paraprofessionals, with minimal supervision by not only by psychiatrists and other physicians but also by psychologists. The problems out there are severe. Clinical depression and psychosis affect Indians as much as anyone else. Adult

children of alcoholic issues are almost the norm, and could benefit greatly from psychotherapy, especially when abuse is a factor. This is my own area of expertise, and I have been impressed with the frequency with which memories of physical and sexual abuse are repressed and denied, yet evident in symptoms of depression and self-destructive behaviors, including substance abuse. Treatment of these problems requires more than ACOA support groups or supportive counseling from a paraprofessional. We need more professionals and we need to pay them more so that we can get highly qualified ones. Then we can train our front-line mental health workers to have a greater awareness of disability and a better understanding of when to refer. At this point the complaint is still valid that it doesn't do us any good to document our needs when there are no resources to meet those needs. We do need more research on the epidemiology of psychiatric disorders among American Indians, but we also need to do something about what we find out.

3. The fragmentation between substance abuse treatment and other mental health services leads to inefficiency and ineffectiveness. This has long been my biggest complaint about the existing system, and it applies not only to the Indian Health Service but to the country as a whole. However, it affects Indians more so, because of their higher prevalence of alcoholism. SUBSTANCE ABUSE IS A MENTAL HEALTH PROBLEM as well a public health problem. It cannot be ignored in mental health treatment if that treatment is to be effective. Trying to treat it in a separate program is inefficient and ineffective and often results in the patient falling between the cracks. I don't need to go into the history of how this split arose in the first place, but old rivalries die slowly, and this one directly affects patient care, much to the detriment of the patient. You, as legislators, could go a long way toward solving this problem by combining the budgets for substance abuse and mental health, and

requiring the administrators for that budget to have expertise in both areas. I know that isn't likely to happen, but I'm suggesting it anyway because ideally, I think that is what should happen. Short, of that, anything that would improve coordination between those two programs would be helpful.

4. Existing community mental health services are underutilized. For the most part this is because of a lack of awareness of and sensitivity to Indian cultural differences, including a lack of effort to coordinate with Indian tribal resources and referral sources. In Michigan, as I believe it is in most states east of the Mississippi, health care on reservations is contracted out, and the one urban Indian health center in Detroit does not have a mental health program, so the majority of Indians in the state who obtain mental health services do so through their local community mental health centers. It is widely recognized that Indians do not utilize these services as much as their needs would warrant.

The reasons for this are several. For many Indians, depression, alcoholism and other mental health problems are a way of life and they don't even realize that help is available. They think you have to be "crazy" to go to a place like that, or in need of institutionalization. A little education, especially about the symptoms of depression and the help available, would go a long way.

For those Indians who do visit mental health centers, follow-through is poor, and we need more data to document this as well as to ascertain the reasons. The two most often mentioned are that they do not feel understood, and that they are treated as individuals in a vacuum without any effort made to deal with their support systems. Time and again, when I talk to the caregivers who are actually treating Indians, they talk about the need for family therapy.

Oftentimes, this includes extended family as well. The people who are delivering care to Indians in mental health centers need to have expertise in treating extended families. They need to have some understanding of the community their clients come from, preferably by going into that community and making themselves visible there as well as getting to know the community people who can serve as resources and referral sources. It would also help if we had more Indians on the staffs of these mental health centers, but in order to do that, we need more Indians to get training in the mental health professions. That gets into the area of educational recruitment and retention, which is equally important, but not our topic at hand today. However, we could and should have more Indian representation on community mental health boards, and we could improve the training of non-Indian therapists in cross-cultural issues and communication.

5. Lastly, I would like to mention that there are problems of jurisdiction with Indians on reservations who are in need of civil commitment to State institutions for reasons of dangerousness to self or others, and to date these problems have had to be worked out locally, with varying degrees of success. The 8th Federal Circuit Court has determined that the states have no authority or obligation to act in such cases, and in South Dakota the state cannot even accept jurisdiction of the tribal court unless there were a vote by the majority of the Indians on the reservation that they could do so. Because the Federal government is mandated and obligated to provide care for these people, I would hope that they could find some way to ameliorate this situation, because many of these Indian people are not getting treatment and often just end up in jail.

In conclusion, Mr. Chairman, I would like to thank you for allowing us this opportunity to present some of our concerns. The problems are at times overwhelming, but we cannot allow ourselves to be overwhelmed. We must do whatever we can, for small steps eventually become big ones and the APA welcomes the opportunity of working with you and together beginning the journey to resolve the problem.

REPORT TO THE SELECT COMMITTEE ON INDIAN AFFAIRS

THE HONORABLE SENATOR DANIEL K. INOUYE,
CHAIRMAN

JULY 7, 1988

A NATIONAL SURVEY ON THE NEEDS OF AMERICAN INDIAN VIETNAM WAR VETERANS

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(Note: This report was largely prepared by Robin A. LaDue, Ph.D., Consultant, National Working Group on American Indian Vietnam Veterans.)

In November, 1983, the Readjustment Counseling Service of the Veterans Administration held the first meeting of the National Working Group on American Indian Vietnam Veterans. The nine members of the Group were American Indian professionals from around the country who worked with Indians and veterans. The Working Group's mandate was to identify the needs of Indian veterans. An immediate concern of the Group was the lack of solid data on the needs and concerns of Indian veterans.

The Working Group conducted a national survey (see enclosed questionnaire) to meet this lack. Respondents were recruited through Vet Centers, the Vietnam Era Inter-Tribal Association, and personal contact. The study ran over a four year period with the data statistically analyzed through the efforts of Dr. Tom Holm of the University of Arizona.

One hundred and seventy American Indian veterans from approximately 60 tribes responded. Almost all (98%) were male and the mean age was 40. The four services were represented with 62% Army veterans, 11% Navy, 21% Marines, and 5% Air Force. Half the sample lived in urban areas; the others lived in rural or reservation communities which is consistent with 1980 Census American Indian data.

Historically, American Indians serve their country in large numbers, well beyond their proportion in the general population. It is estimated that 20% of all American Indian men are veterans. In the study 79% of the sample enlisted; only 21% were drafted. 87% served in Vietnam. The most common MOS was infantry or rifleman and 64% felt they saw moderate to heavy combat; this self report is supported by the 234 decorations and awards won by the 147 who served in Vietnam (see Table One). Most (65%) served in Vietnam between 1965 and 1969 and 12% did more than one tour. As was true of their nonIndian peers, their average in Vietnam was 19.

The statistics are impressive. They show a high level of volunteerism and a high level of combat. With a high frequency and severity of combat exposure, a significant number of psychosocial problems are to be expected. That is what the study found. However, though an elevated level of psychosocial problems were reported we also found a low level of seeking help.

The survey asked specific questions about drug and alcohol use, symptoms of post-traumatic stress disorder (PTSD), and a range of social problems (e.g., employment). The results of the survey were startling: 81% of our sample indicated mild to severe problems with alcohol abuse after Vietnam with only 42% feeling they had resolved the problem. Drug abuse after Vietnam was not as high (32%), though only 34% felt they had overcome this problem.

PTSD symptoms were a significant problem with 80% experiencing mild to severe depression, 76% having sleep disturbances, 64% having flashbacks, and 71% have problems with anger and rage. The majority, 64%, of veterans reporting these problems had not sought help through the Vet Center program.

A surprising result was the high education level of the participants. The majority (92%) had either graduated from high school or held equivalency degrees and 61% had some college experience. Despite this high education level, 40% of the sample were unemployed.

Another area examined were the reasons why the American Indian veterans entered the service. For many it was a family and tribal tradition to serve. They felt their families and tribes supported and appreciated their efforts--this is in contrast to the attitude of American society as a whole, which until recently treated Vietnam War veterans as outcasts.

To summarize the results of the survey, The Working Group found American Indians volunteered in high numbers, served at a disproportionally high rate in combat, came home with the same emotional problems as other Vietnam War veterans, had more cultural and social supports than their nonIndian counterparts, but still had unresolved issues. Only one third sought services through the VA Vet Center program.

The Working Group members believe there are significant barriers to American Indian veterans getting services from the Veterans Administration. These barriers include few facilities in Indian Country and long distances to the few available facilities, distrust of government programs in general, a lack of Indian people involved in providing the services, and a failure by providers to understand the special needs and culture of American Indians.

We feel the proposed initiative to establish a comprehensive community based mental health services program staffed by qualified Indian people is desperately needed. The Working Group and, we are informed, the Vietnam Era Veterans Inter-Tribal Association would like to see another more comprehensive survey conducted among American Indians more closely paralleling the recently completed study of Vietnam War veterans conducted by the Veterans Administration and from which American Indians as a group were excluded.

Our experience shows Indian people are concerned and will express their opinions. While many of the issues highlighted here are not restricted to veterans and are endemic to the Indian community, it is very clear that American Indian Vietnam War veterans have particular problems resulting from their service to their country. Given the earned help, we feel these veterans can become leaders for their people as was and is the tradition of many tribes.

SERVICE PROVISION AND TRAINING ISSUES

The National Working Group on American Indian Vietnam Veterans is concerned with the type and quality of services offered to Indian veterans as well with identifying the special needs of this population. We attempt to monitor those providing services ensure their work is done in a culturally sensitive and appropriate fashion. The Working Group has indicated repeatedly its concern to the Veterans Administration as to which professionals and tradional healers should be providing training to VA staff.

Over the years several situations were brought to our attention where inappropriate use of so-called "Indian" ceremonies are used with nonIndian veterans. Also, nonIndians are providing training to VA staff on "culturally-appropriate" methods of intervention and treatment of American Indian veterans.

It is the strong opinion of the Working Group that only those persons qualified and recognized within the Indian community as legitimate, first, should be conducting any type of traditional ceremony or ritual whether it is for Indian or nonIndian veterans and, second, should be providing the crosscultural training. The legitimate people are available and the Working Group and the Vietnam Era Veterans Intertribal Association, to name two groups among several, can serve as clearing houses for linking qualified people with those desiring such training and services.

We also believe that any contract services for veterans in the Indian community should be conducted through and with the aid of local Indian agencies such as the tribal governments or the Indian health boards. To help achieve these goals, the Working Group helped draft and requested the acceptance of a policy statement for the Veterans Administration's Readjustment Counseling Service covering the use of traditional healing practices and the training of VA staff. A copy of this darft is enclosed.

We greatly appreciate the Select Committee on Indian Affairs giving their time and attention to this matter. It will be the pleasure of the Working Group to aid the Select Committee in any way possible.

Table One

Additional Military Service Data

Average military rank at discharge	E-5
Total serving in the Vietnam War	147 (86.5%)
AWARDS	
Purple Hearts	72
Personal Foreign Awards	29
Navy Achievement/Army Commendation	51
Air Medals	22
Bronze Stars	43
Silver Stars	15
Distinguished Service Cross	2
Total	234

Note: Includes multiple awards

Currently disabled	46

VEVITA
P.O. Box 25742
Oklahoma City, Okla 73125

June 27, 1988

Dr. Robin Ladue, PhD
Consultant American Indian Working Group
Seattle, Washington

Dear Dr. Ladue:

I understand that you were to testify to the senate select committee on Indian affairs on behalf of the American Indian Vietnam Veterans. I understand that you have written a Report on the survey on Indian vietnam veterans and that this report will be presented to the committee. As Executive Director of the Vietnam Era Veterans Inter-Tribal Association (VEVITA), I would like to request that you propose on our behalf that funds be allocated to perform a National Survey on American Indian Veterans and that the VEVITA be the prime contractor for performing this study.

The veterans administration has traditionally neglected the needs of the Indian Veteran. Such as:

1. American Indian veterans were excluded from the National study on vietnam era veterans.

2. In 1982 the Vet Center implemented the following working groups (Women, Blacks and Hispanics) to address the unique needs of these special populations. Not until One year later, did the VA implement the american indians working group.

3. Within readjustment counseling service only six american indians are identified as working with in this program.

4. In fiscal year 1988 each working group was allowed by the VA to hold it's annual meeting with the exception of the american indians working group who meeting was arbitrarily cancelled.

On June 9-12, 1988, the VEVITA held it's 7th annual national conference and pow-wow. During this meeting, the VEVITA adopted a formal plan for a regional development strategy, that is currently being implemented by the membership. In additon, the VEVITA is currently in the process of an extensive membership drive and now has a professional publication entitled "REDSMOKE" that bridges the gap between Native American Veterans. This publication was develop to allow for the VEVITA to serve as a national clearing house for Indian Veterans news and information that is presented in a culturally sensitive format to native american veterans.

We are in the process of starting a formal dialog with the Vietnam Veterans of America (VVA), National Vietnam Veterans Coalition (NVVC) and VA readjustment counseling service American Indian Working Group.

I have enclosed 5 copies of REDSMOKE for your review. Thank you for your consideration concerning this request. I hope to hear from you in the near future. Should you need any additional information you can call me at 405-692-1202.

Sincerely

Matthew W. Kauley
Executive Director

REPORT TO THE SELECT COMMITTEE
ON INDIAN AFFAIRS

THE HONORABLE SENATOR DANIEL K. INOUYE,
CHAIRMAN

JULY 7, 1988

A NATIONAL SURVEY ON THE NEEDS OF AMERICAN INDIAN VIETNAM VETERANS

ROBIN A. LaDUE, Ph.D.
CLINICAL PSYCHOLOGIST
CONSULTANT, NATIONAL WORKING GROUP
ON AMERICAN INDIAN VIETNAM VETERANS

ROBIN A. LaDUE, Ph.D.
Clinical Psychologist
LIC. #954

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In November, 1983, the Readjustment Counseling Services of the Veterans Administration held the first meeting of the National Working Group on American Indian Vietnam Veterans. The nine members of the group were American Indian professionals from around the country who had worked with Indians and veterans. A major concern of the Group was the lack of solid data on the needs and concerns of Indian veterans.

To gather data, a questionnaire was devised (see enclosed questionnaire) and distribution began across the country. Respondents were recruited through Vet Centers, the Vietnam Era Veterans Inter-Tribal Assocation (VEVITA) and word of mouth. Data was collected over a four-year period and analyzed through the efforts of Dr. Tom Holm of the University of Arizona. The information contained in this report is based on the results of the survey.

The survey was administered on an individual basis to 170 American Indian veterans from approximately sixty tribes from across the country. The vast majority (98%) of the sample were male and the mean age of respondants was forty years. The four main branches of the service were represented with 62% having served in the Army, 11% in the Navy, 21% in the Marines, and 5% in the Air Force. Half the sample lived in urban areas, the other half in rural or reservation communities. This is consistent with data on Indians from the 1980 census.

Historically, American Indians have served their country in large numbers, often beyond their proportion in the general population. It is estimated that 20% of all American Indian men are veterans. In the current study, 79% of the sample enlisted; only 21% were drafted. With an enlistment rate of 79%, 87% served in Vietnam, their primary MOS was infantry, and 64% felt they had seen moderate to heavy combat. The average dates of service in Vietnam were 1965 to 1969 (61%) with 12% doing more than one tour. As was true with many Vietnam Veterans, the average age of these Indians during their time in Vietnam was nineteen years.

In and of themselves, the statistics given are impressive. They show a high level of volunteerism and a high rate of combat. Because of this high rate of combat, a significant number of psychosocial problems might also be expected. These issues were of particular interest to the Working Group as our mandate was to identify and address special needs of Indian veterans. Those veterans who participated in our survey indicated an elevated level of psychosocial problems but a low level of seeking help.

The survey asked specific questions regarding drug and alcohol use as well as symptoms of post-traumatic stress disorder (PTSD) and social problems, e.g. employment. The results of the survey were quite startling; 81% of our sample indicated mild to severe problems with alcohol abuse, post-Vietnam, with only 42% feeling they had resolved this problem. Drug abuse after Vietnam was not as high among this population(32%) as alcohol abuse with 34% feeling they had overcome their drug problem.

PTSD symptoms were a significant problem among our sample with 80% experiencing mild to severe depression; 76% having sleep disturbances; 64% indicating problems with flashbacks, and 71% having difficulties with uncontrollable anger and rage. The vast majority (64%) of Indian veterans reporting these problems had not sought services through the Vet Center program.

Another surprising result from the study was the high education level among the participants. The majority (92%) had either graduated from high school or held equivalancy degrees and 61% had some college experience. Despite this high education level, 40% of the sample were unemployed.

Another area the sample addressed was the reason people entered the service. For many of these veterans, it was a tradition of their families and tribes to serve. The veterans participating in the study felt their families and tribes were supportive and appreciative of their efforts in contrast to American society, in general, who, until recently, have treated Vietnam veterans as social outcasts.

In summarizing the results of the survey, the Working Group found that Indians volunteered in large numbers, served at a disproportionately high rate in combat, came home with the same emotional problems as other Vietnam veterans, had more cultural and social supports than their non-Indian counterparts, but still had unresolved issues. Only one-third of the survey had sought services through the Vet Center program.

It is felt by members of the Working Group that there are significant barriers to Indian veterans receiving services. These barriers include few facilities in Indian Country, long distances to available facilities, distrust of governmental programs, in general, on the part of Indian people, a lack of Indian people providing the services, and a failure on the part of providers to understand the special needs and culture of Indian people.

We feel the type of initiative proposed to help establish a comprehensive community-based mental health services program, staffed by qualified Indian people, is imperative. The Working Group and Vietnam Era Veterans Inter-Tribal Association would like to see another, more comprehensive survey conducted throughout Indian Country.

Our experience showed that Indian people are concerned and will give their opinions. The problems of unemployment, depression, and alcohol abuse coupled with few services do not just affect Indian veterans. These are issues throughout Indian Country. However, we do feel, given the response of the veterans in the sample, that Indian veterans can become leaders to their people as was and is the tradition of many tribes.

SERVICE PROVISION AND TRAINING ISSUES

The National Working Group on American Indian Vietnam Veterans has been concerned as to the type and quality of services offered to Indian veterans as well as trying to identify the special needs of this population. In addition, we have attempted to monitor those providing services to assure such services are done in a culturally sensitive and appropriate fashion. The Working Group has indicated their concerns to the Veterans' Admistration as to which professionals and/or traditional Native healers should be providing training to VA staff and personnel.

Over the years, several situations have been brought to the attention of the Working Group where inappropriate use of "Indian" ceremonies are being used to "treat" nonIndian veterans. As has also, all too frequently, been the case, nonIndian professionals are providing training to VA staff on "culturally-appropriate" methods of intervention and treatment of Native veterans.

It is the strong opinion of the members of the Working Group that only those persons qualified and recognized within the Indian community as legitimate should (a) be providing such training and/or (b) conducting any type of traditional ceremony whether it be for Indian or nonIndian veterans. The Working Group and the Vietnam Era Veterans Intertribal Association can serve as clearing houses for linking qualified people with those desiring such training and/or services.

We also feel that any contract services for veterans in Indian country should be conducted through and with the aid of local Indian agencies such as the tribes or the health boards. To help achieve these goals, the Working Group has helped draft and requested the acceptance and the implementation of the attached policy statement regarding the use of traditional healing and training of VA staff.

We greatly appreciate the Select Committee on Indian Affairs giving their time and interest in this matter. It will be the pleasure of the Working Group to be of aid to the Select Committee in any way possible.

Thank you.

Survey of American Indian Vietnam Era Veterans

I. Background Information

1. Tribe(s) ____________________

2. Male _____ Female _____

3. Date of Birth ____________________

4. Branch of Service ______________ Dates __________

5. Were you drafted? ___yes ___no

6. Did you serve in Vietnam? ____yes ___no

   If yes, please give your dates of service in country and the unit (if unclassified) you served with ____________________

   ____

7. Please indicate the area(s) in Vietnam in which you served (I Corps, Mekong Delta, Saigon, etc.) ____________________

   ____

   ____

8. Highest rank attained? ____________________

9. Were you wounded in action? ___yes ___no

10. Are you currently disabled? ___yes ___no What % _______

11. Military MOS? ____________________

12. Individual decorations? ____________________

    ____

    ____

13. Would you say that you saw:

    ___heavy combat in Vietnam

    ___moderate combat

    ___light combat

    ___no combat

14. Specialized training? (Airborne, Ranger, SF, Recon) ______________

    ____

15. Where do you now reside?

___Reservation

___Rural non-reservation

___Urban area

16. Did you grow up:

___on a reservation

___in a non-reservation rural area

___in an urban area

___sometimes rural/reservation, sometimes urban

17. Current marital status?

___married, please indicate if this is the 1st, 2nd, etc. __________

___separated

___divorced

___widowed

18. Educational level? ______________________________

19. Profession/skill? ______________________________

20. Are you currently employed? ___yes ___no

21. Do you speak your tribal language

___fluently

___in words and phrases

___not at all

II. Personal reactions/opinions

1. Do you have good feelings about the period you spent in the military service? ___yes ___no ___sometimes. Please explain: __________

____

____

____

2. How important was each of the following in your decision to enter the military service or accept being drafted?

Patriotic duty:
___very important ___somewhat important ___not too important ___not important at all

Financial security:
___very important ___somewhat important ___not too important ___not important at all

Gain respect from Indian people:
___very important ___somewhat important ___not too important ___not important at all

Gain respect from non-Indians:
___very important ___somewhat important ___not too important ___not important at all

Family tradition:
___very important ___somewhat important ___not too important ___not important at all

Tribal tradition:
___very important ___somewhat important ___not too important ___not important at all

3. When you were in the service, were you ever subjected to discrimination of any type? ___yes ___no. If yes, please describe: ________________

____

____

4. Have you ever regretted the fact that you served in the armed forces? ___yes ___no. If yes, in what ways? ________________________

____

____

5. Have you ever suffered from any of the following as a result of your combat duty or homecoming experience? Please indicate in the far right hand column if you feel you've overcome, recovered from or worked through the problem.

Alcohol problem	___severe	___mild	___none	___yes	___no	___unsure
Drug problem	___severe	___mild	___none	___yes	___no	___unsure
Depression	___severe	___mild	___none	___yes	___no	___unsure
Sleep disturbance (bad dreams, nightmares, etc.)	___severe	___mild	___none	___yes	___no	___unsure
Flashbacks	___severe	___mild	___none	___yes	___no	___unsure
Uncontrollable anger, rage	___severe	___mild	___none	___yes	___no	___unsure

6. Have you had any other problems you'd like to mention? ____________
____
____
____
____

7. Do your tribal traditions recognize and honor its veterans? ___yes ___no
___unsure

8. Were you given any traditional ceremonies either to prepare you to leave for the military and/or upon your return home? ___yes ___no
If yes, what type?
___soldier dance
___induction into a traditional warrior society or clan
___prayer meeting
___feast
___Peyote meeting
___purification ceremony
___other, please describe ______________________________
____
____
____
____

9. When you entered the service, did the military ever list you as something other than American Indian or Native American? ___yes
___no ___unsure. If yes, was it:
___Hispanic (with Spanish surname)
___"other"
___mongolian
___caucasian/white
___negro/black

10. Do you know what the Vet Center Program is? ___yes ___no

11. Have you ever sought services at a Vet Center? ___yes ___no
If yes, please describe: ______________________________
____
____
____
Were you satisfied with the services? ___yes ___no ___mixed feelings

12. Are you concerned with any of the following?
___Post Traumatic Stress Disorder
___Agent Orange Exposure
___Discharge Upgrades
___Employment
___Other, please explain: ______________________________
____
____
____
____
____

13. Do you now or have you ever belonged to any national Indian organizations? (i.e. NCAI, NIEA, NIYC, AIM, etc.) ___yes ___no

14. Any veterans' groups? ___yes ___no

15. Do you vote in tribal elections? ___yes ___no

16. Do you regularly vote in local, state or national elections? ___yes ___no

17. Have you ever held elected tribal office? ___yes ___no

18. Do you think your tribal government is "getting the job done" well? ___yes ___no ___unsure

19. Do you think the federal government has pursued a fair policy toward Indian people? ___yes ___no ___unsure

20. Do you think your tribal government has a fair policy toward tribal members who are Vietnam veterans? ___yes ___no ___unsure

21. Do you think the federal government has pursued a fair policy toward Vietnam veterans? ___yes ___no ___unsure

22. Do you think that non-Indians in general have positive attitudes toward Indians? ___yes ___no ___unsure

23. Do you think that non-Indians in general have positive attitudes toward Vietnam veterans? ___yes ___no ___unsure

24. Do you think that Indian people in general have positive attitudes toward Vietnam veterans? ___yes ___no ___unsure

25. Do you think your tribal government is representative of your people? ___yes ___no ___unsure

26. Do you think of tribal elders as: (check as many as are appropriate)
___persons to be revered
___old fogies
___persons to be pitied
___living in the past
___living history
___ignored by the tribal government
___ignored by younger Indian people
___teachers
___politically powerful
___persons of authority

27. Do you believe that traditional ceremonies can aid Vietnam veterans in overcoming their problems? ___yes ___no ___unsure

28. Would you consider yourself to be:
___traditional
___non-traditional but interested in keeping tribal traditions alive
___traditional but removed from your homelands and tribal customs
___non-traditional and not interested in tradition

29. Do you have any comments on this questionnaire or your experiences as an American Indian veteran? Please use the reverse side of this sheet.

*****Draft*****

DATE: October 8, 1987

FROM: Director, Readjustment Counseling Service (10B/RC)

SUBJ: READJUSTMENT COUNSELING SERVICE POLICY MEMO #___:
TRADITIONAL HEALING AND SPIRITUAL PRACTICES AND RITUALS

TO: All Regional Managers (10B/RC1-7)

PURPOSE: To establish guidelines regarding traditional spiritual and healing practices offered under the auspices of Readjustment Counseling Service.

INTRODUCTORY STATEMENT: Due to the nature of readjustment counseling and in some instances, its parallel to certain traditional spiritual and healing practices, there may be a natural attraction to combining, presenting, or otherwise simulating the processes. It is necessary to establish guidelines which are consistent with Agency standards and good practice:

To ensure proper regard for traditional healing rituals/methods against commercialization, misuse, and misinterpretation.

To ensure adherence to the ethical and legal standards governing counseling services in the Readjustment Counseling Service.

POLICY:

1. RCS counseling staff in general should not participate or present themselves as advisors, presentors, guides, orientors, or staff in connection with any traditional healing or spiritual method, either publicly or privately, on the basis that their training and cultural background does not qualify them for such roles.

One exception to this specification would be that a program employee of the appropriate cultural origin (Native American, Hispanic, Haitian, Asian, etc.) who has appropriate training, initiation, and endorsement, etc., by a legitimate traditional organization could function in a role permitted by that organization -- on his/her own time; not on VA time.

2. In keeping with good practice, an RCS employee who has developed a professional interest and familiarity in a traditional healing method and desires to present a professional work on the subject, is expected that such papers or presentations make it clear whether or not the individual has any kind of endorsement or authorization from a traditional

organization, and if so, specify the nature of the endorsement, and if not, specify that and that the paper or presentation is presented solely from the point of view of a professional social worker, psychologist, etc.

3. Caution should be exercised in making referrals to any healing art activity. Consultation should be sought from appropriate representatives (e.g., from a Native American working group) whenever sanctioning of an activity or service provider or the appearance of same is in question.

ARTHUR S. BLANK, JR., M.D.

F2/mm/mm - "healing.pol"

Otoe-Missouria Tribe

P. O. Box 68, Red Rock, Oklahoma 74651 - Phone (405) 723-4334

Mr. Chairman and Members of the Committee. My name is Marlene Echo Hawk, I'm a Clinical Psychologist and a member of the Otoe-Missouria Tribe from Oklahoma, I appreciate the invitation to provide testimony on behalf of my tribe and in my capacity as a mental health professional.

I will keep my statement brief.

The Otoe-Missouria Tribe commends the Select Committee on Indian Affairs for their concern for the mental and emotional-health care needs of American Indian and Alaska Natives.

1988 marks the twenty-fifth year since the Community Mental Health Systems Act was passed in 1963. Looking back, we can assess what methods have been found to be most efficacious in the treatment of mental disorder for those utilizing community mental health centers. Reasonably, we can integrate that knowledge with traditional American Indian and Alaska Native healers approaches to mental health.

What is sometimes considered innovative has really been around a long time. For example, Native Americans, for centuries, have utilized art, song, and dance as well as medicine to help tribal members who are mentally disturbed to respond to their emotions. Over the years we have seen many of our valuable Native American treatment approaches under-utilized and even ridiculed, but mostly ignored by those not understanding the full meaning and value of traditional Native American healers. As a Native American clinical psychologist I enthusiastically envision a blending of all we know about the treatment of mental disorders for the total well-being of Native Americans and Alaska Natives.

Over the years the erosion of the Native American and Alaska Natives Cultures has taken its toll. The physical, mental and social functioning of Native Americans has been seriously damaged. Like fertile soil that provided abundently, the erosion process has been set in motion. We are now talking about reversing this process by conserving what is left and eventually restoring fertile ground.

This is an exciting and unique time to consider comprehensive community based mental health services for Native Americans and Alaska Natives.

The Otoe-Missouria Tribe:

1. Supports the concept of comprehensive community based mental health centers.

2. Acknowledges the need for cultural sensitivity regarding mental health treatment for Native Americans and Alaska Natives.

3. Strongly recommends the integration of traditional medicine peole into the comprehensive community based mental health centers.

4. Will be honored to work with this Committee over the coming months to develop a multidisciplinary approach to a community based mental health and legislative program.

Finally, the Otoe-Missouria Tribe has a strong friendship with the Navajo Nation of Arizona. My colleagues from the Navajo Community College wished me to submit a document on their behalf with the testimony I have just presented.

Marlene Echo Hawk

Marlene Echo Hawk, Ph.D
Otoe-Missouria Tribe
Clinical Psychologist

WIND RIVER July 7, 1988

Mr. Chairman:

Since the fall of 1986, youth like myself are searching for ways to make a difference. The Youth Council at Wind River Reservation has been through good times and bad times; highs and lows. But we all feel that what we are doing means something. We have all made an impact in one form or another on our community. The Youth Council "family" grows with every accomplishment. Every conference or event has some kind of meaning, and we are able to share it with each other. We have grown in many ways since the fall of 1986, but more important is that we are giving the youth a voice.

It has been fun working with the different people we come in touch with. They are support to the Council, but for us to move on, we need to have even more support. We have 22 members on the Council. It covers both the schools and communities. The Council has been going for two years and each year it has become more and more strong. We are only one of five youth councils across the Nation.

The activities that the Wind River Reservation Youth Council has participated in are:

1. It sent members to Minnesota in the summer of 1987 to take part in a leadership camp.
2. It sent members to Scottsdale, Arizona, to take part in the "Youth and Entreprenuership Conference," hosted by the Council for Tribal Employment Rights (CTER) as part of the Indian YOUTH 2000 campaign this year.
3. It sent members to Chandler, Arizona, to attend a youth conference on Drug and Alcohol Abuse Prevention.
4. It sent delegates to the UNITY conferences both in Denver in 1987, and in Washington, D.C. in 1988.
5. It had some input into the Wind River Reservation Youth Conference, such as themes and activities.
6. It held a booth at the Wyoming State Winter Fair, which gave information about Youth Councils, and had membership cards available.
7. It visited the State Capital in Cheyenne. It was also where we decorated the Governor's Christmas tree. It was decorated with Indian beadwork from people on the reservation, and displayed at the Governor's mansion over a month's period until Christmas.

8. It met with the Governor of Wyoming.

9. It took on a project for the summer of 1988 called "The Living History of Indian Village." It is a home which also serves as the Wind River Reservation Youth Council headquarters.

   The village itself helps to inform the public about the Native American traditions. It also informs the public of the cultures of the Arapaho and Shoshone tribes.

10. We are invited to talk to the public about the Youth Council's activities, agendas, meetings and accomplishments once a month on two different radio stations. We have also been interviewed on a local television news station.

Our Youth Council provides a voice for young Indian people.

Our Goals

* To promote and establish Indian leadership among the reservation youth.

* To educate the public about the Native traditions for future generations to understand and value the cultures.

* To promote activities designed to strengthen the spirit, mind, and body in keeping with Native tradition.

UNITY has played a very important role in the development of the Youth Council. Through UNITY, we have been able to come to terms with our Tribal Council. We have also been able to spread our success with other delegates from other reservations.

We hope that withthe help of the UNITY organization, other tribal governments will start Youth Councils.

The youth represent Indian Country's most prized natural resource. Today the youth are realizing this and are pulling together to "Make a Difference!

It is with UNITY's help that the youth on the Wind River Reservation can enjoy the healing of their great nation.

Edward "Eddie" Wadda
President
Wind River Reservation Youth Council
Box 443
Fort Washakie WY 82594

(307)332-2106

July 7, 1988

Greetings Mr Chairman:

My name is Vivian Juan of the Tohono O'odham Nation, formerly Papago, from Sells, Arizona. Presently I serve on the Board of Trustees of United National Indian Tribal Youth, Inc. (UNITY), a national youth organization serving the social, spiritual, physical, and emotional needs of American Indian and Alaska Native youth.

Since assuming responsibility for promoting and teaching positive self development and personal empowerment to youth, I recognize the need for adequate and professional mental health care for our people.

Each generation of youth is continually reminded that "They are Tomorrow's Leaders, Tomorrow's Future!" Five years ago, I began to evaluate this statement, and the implications of its interpretation. At this time I recognized the lack of positive role models and programs to provide positive affirmation to American Indian and ALaska Native youth. I began to challenge the leadership of Indian country by voicing my concern with the following: "Quit telling me that I am tomorrow's leader. Teach me by your examples, and by the skills you want me to learn in order to be the Leader of tomorrow.

It is my vision that the future will be one where individuals will feel proud of their culture and personal achievements through programs implemented with the assistance of appropriations necessary to promote the unlimited potential that lies within the bounderies of Indian Country.

Approximately 1.5 million American Indians and Alaska Natives live in the United States: about half of this number live on reservations--the remaining live in urban or off-reservation communities. There are over 300 Federally recognized tribes, and 200 Alaska Native villages. Over half of the American Indian and Alaska Native population is under the age of 22.

What will the year 2040 be like for this population and those yet to be born? Many of us here today will not be alive in 52 years; our children and grandchildren will be the generation sowing the fruits of our efforts we make today, or it could be the generation suffering from the inability to see the vision of wellness and hope. It is our efforts today that will determine the mental, physical, spiritual, and social welfare of our people.

Presently I am 27 years of age, through the recognition of the need for programs that provide positive self esteem and motivation — I have been fortunate to have travelled to 35 states in the country. 3/4 of the visits have been to American Indian and ~~Alaska Nat~~ive communities. I see a need for an increase in the number of trained and educated individuals to continue this important mission.

Youth are eager to learn and continue the state of motivation and hope through the programs I have offered. However, there is a definite need for continued efforts by tribal councils and departments on all levels of government to provide a long range plan of action to provide the environment necessary to ensure stability and continuity of wellness and hope.

Through the financial resources obtained the following solutions can be implemented:

(a) Establish reservation and Indian and Alaska Native community youth councils to allow youth to solve the problems that involve themselves.

(b) Build a permanent structure for use as a youth center. This will be a place for youth to gather, hold activities, as well as provide workshops on positive self-esteem, preventative measures with regard to alcohol and drug abuse, cultural awareness, health and mental wellness.

(c) Train individuals who have a commitment to youth, to manage and assist with the youth center.

(d) Identify and train youth peer leaders to provide peer training in the workshops mentioned.

(e) A network of youth can be established in order to continue to share ideas that will assist youth nation-wide.

I am a product of a reservation. Although the problems of alcohol, drugs, and child abuse are evident, I have witnessed a change among my people due to the healthy and positive affirmation that programs have provided. I also recognize that the traditions and cutural awareness was included in the implemetation of thse programs. We are a confident people, happy and on the road to recovery.

The greatest achievements made in history have been those that have benefited generations yet to be born. I strongly urge you to consider appropriations for American Indian and Alaska Native youth programs. The mental health of our youth today will determine the future stability of our nations. I urge you to think about what kind of environment you want your grandchildren to live in, this will provide a very real vision of what we must do today. Thank You.

Vivian Juan
P.O. Box 141
Sells, Arizona
85634

UNITED NATIONAL INDIAN TRIBAL YOUTH, INC.

4010 Lincoln Blvd., Suite 202
P.O. Box 25042, Oklahoma City, OK 73125
Phone: (405) 424-3010

Mr. Chairman:

United National Indian Tribal Youth, Inc. (UNITY) is a national, non-profit organization designed to develop leadership, promote self-suficiency, and instill cultural pride among American Indian and Alaska Native youth. An outgrowth of a successful Indian education program serving Indian youth in 10 western Oklahoma public schools, the organization was incorporated in the State of Oklahoma in 1976. UNITY is governed by an all Indian Council of Trustees and headquartered in Oklahoma City.

UNITY has sponsored 14 national youth leadership conferences in New Mexico, Montana, Oklahoma, Illinois, California, Arizona, Colorado, and Washington, D.C.

Emphasizing a greater voice for Indian youth, UNITY officials worked cooperatively with staff members of the House Committee on Interior and Insular Affairs to plan and schedule a special hearing in which youth attending the UNITY conference in Washington, D.C. in 1986, could offer their personal testimonies on H. R. 1156, the "Indian Youth Alcohol and Substance Abuse Prevention Act."

At another conference, a young lady picked up a UNITY newspaper. She was from Wind river reservation, and she related that all the experts had been there and studied their recent suicide epidemic, but nothing was happening. She sent the UNITY newspaper to her aunt in Wind River who in turn passed it along to the supervisor of the Community Health Representatives (CHRs) at Wind River.

As Executive Director of UNITY, I was invited to visit the Wind River reservation in Wyoming. My purpose was to offer some assistance in addressing their epidemic of youth suicides. Twelve young people had taken their lives in about nine weeks. I came up with a very simple answer: Have the youth address the problems, and address their concerns by building a mechanism in the tribal structure that can work with the youth.

My philosophy is best described by a story Henry Ford used to tell. When Henry Ford wanted unbreakable glass, he said in effect: "Don't bring me all of the experts--the scientists and the engineers--they know too many reasons why it can't be done. Instead bring me eager young men and women who don't know the reasons it can't be done!" As we all know, Henry Ford got his unbreakable glass.

Pat Bergie, the CHR supervisor, scheduled meetings with the Service Unit Director of the Indian Health Service, the Acting Superintendent of the Bureau of Indian Affairs Agency, educators, community leaders, the members of the Shoshone Business Council, and the Arapahoe Business Council, so that she and I could obtain information and develop a plan of action. UNITY's concern was that too many experts were studying the youth, but that no one was listening to them.

UNITY listened to the youth. The resulting resolution in effect prioritized the local youth issues at Wind River, established a Youth Affairs Committee, and authorized the formation of a Tribal Youth Council. The resolution was presented to the Joint Business Council at Wind River, and was passed without opposition. Incidentally, this took place within a three day time span.

The testimony of Edward "Eddie" Wadda, the President of the Youth Council today, will describe the outcome and progress for the youth at Wind River since the fall of 1986.

UNITY GOALS

- To generate a voice for American and Alaska Native youth at the Tribal, community, State, and national level
- To harness the power, energy and creativity of Indian youth to build a strong social and economic infrastructure within each Tribe and community

- * To prepare Native American youth to fill leadership roles within their Tribes, communities, states and the Nation
- * To build a cadre of talented Indian and Alaska Native youth that represents a combination of fields and interests in social, economic, and governance areas
- * To accelerate the use of Indian and Alaska Peer role models to combat negative peer pressure, address youth concerns (alcohol and drug abuse, suicide, teenage pregnancy, school dropout issues)
- * To share all Native American positive and leadership approaches that are eliminating negative social conditions in Indian Country

UNITY's goals are predicated on the premise that the way to bring about the most rapid and most lasting change and transformation is to strengthen the governments of all Tribes and Alaska Native communities by empowering the Indian youth to use their talents and creative energy through leadership experiences.

Strong, stable Tribal governments will produce economic well-being and social stability on Indian reservations and Native American communities, which in turn contribute to the overall strength of the states and the Nation. Native American youth can no longer have their talent wasted and their creative energies kept waiting to be utilized in building or strengthening their Tribes and communities.

Imposed values, systems, solutions--whether they be social, economic, or governmental--create dissatisfaction, disharmony and stagnation. Creative Native approaches, equitable partnerships, and attitudes of acceptance in many areas are yet to be tried. But the evidence points to their successful outcomes for Indian people.

It is toward this end that our greatest natural resource is our youth and children, which must be supported and nurtured through community participation beyond just schooling, in order for Native Americans to survive as a people--and as distinct fully functioning cultural and governmental entities which will prosper and flourish.

And yet, throughout Indian Country, there is very little evidence programmatically, organizationally, or structurally, to demonstrate a commitment to youth participation through a planned and sequenced national thrust.

Efforts to develop strong and capable tribal enterprises and tribal governments are almost sure to fail without well qualified and trained leaders to manage them; to lead them. In this regard, commitment to Indian youth, their education, and their participation in the problems and situations that affect them, is of critical importance, as well as the youths' commitment to their tribes and communities, if Native Americans are really to achieve self sufficiency through self determination.

Unless there is a concerted, cooperative effort, to include such strategies into overall long range legislative intiatives, as the beginning of a foundation for reservation and urban Indian communities that they can in turn build on, the permanent infrastructure--which combines the economic, social and governmental coordination necessary that is so desparately needed--will continue to elude us all.

The UNITY "Youth Can Make a Difference" Indian YOUTH 2000 Campaign

To achieve measurable gains in the current situations for Indian youth in terms of school dropouts, substance abuse, crime and accidents, teen pregnancy, and suicide, UNITY knows that a strong leadership campaign for American Indian and Alaska Native youth must contain these important elements:

* Providing a voice for the youth in a community
* Identifying and utilizing Indian peer role models
* Developing the self confidence and cultural pride in the youth
* Strengthening family values

- Teaching effective communication skills to the youth
- Preparing American Indian and Alaska Native youth to function within their tribal governments
- Strong tribal government involvement in all the youth activities in their communities
- Offering specific opportunities for spiritual, mental, physical and social growth to the youth
- Recognizing youth for their accomplishments
- Encouraging voluntary public service by the youth in their communities and by the adults for youth activities
- Educating and involving the youth in the local communities in the free enterprise system
- Allowing Indian and Alaskan youth the opportunity to help resolve the problems affecting them--alcohol and drug abuse, suicides, teenage pregnancy, idle time, lack of peer models, etc.

The UNITY Action Plan for Forming Tribal Youth Councils

As part of the Indian YOUTH 2000 campaign, and to put into place at the local level formal mechanisms for youth that "will make a difference", UNITY is promoting forming Tribal Youth Councils in Tribal communities and in urban areas.

Each Tribal Youth Council formed is tailored to meet the unique needs of the particular tribe or urban community. However, the basic principles underlying them all are:

- Strengthening family values
- Maintaining the tribe's culture and traditions
- Coping with peer pressures
- Building self esteem
- Enhancing skills in communications
- Understanding tribal government
- Allowing youth to help resolve the problems affecting them
- Tribal government and community participation with the Youth Council

It is imperative, that on Indian youth issues, the various federal and state agencies, national Indian organizations, tribal leaders, the private sector, and concerned community leaders, joint forces in a planned manner and with common goals, to utilize the vast amount of untapped resources that American Indian and Alaska Native youth represent--"unlimited potential" as they describe themselves--to equip them with the necessary leadership tools to face the complex challenges of the 21st century.

Until YOUTH 2000, and it is just in the "awareness" stage, there has been a recognized lack of any well-coordinated youth leadership development in Indian Country. We have a rare opportunity to focus on American Indian and Alaska Native youth to bring about meaningful and permanent positive change for Native American youth, with the full participation of their Tribes, families, and communities.

The UNITY concept is to transform current malaise, indifference, and alienation which characterizes the youth into that of pride, strength, and active leadership participation in tribal and urban communities, and the total American scene of which they are a part.

Launching American Indian and Alaska Native YOUTH 2000

Although there have been, and there will continue to be, major national, state and local activities conducted to schieve YOUTH 2000 goals, there was very little opportunity for participation by Tribes, Native American organizations, and American Indian and Alaska Native youth.

UNITY has launched a national campaign for Indian YOUTH 2000 specifically adapted to address the unique needs and values of Indian Country, and designed to reach all tribes, Alaska communities, Oklahoma counties, and urban Indian organizations. This campaign was designed so as not to fail, as have so many other prominent youth organizations have failed, in their efforts to involve Indian youth and their tribes and communities as vehicles for positive change. How? The campaign, its activities, outreach, and focus, are specifically adapted and designed so that Indian youth and their families can understand their role in it--and what that means between now and the year 2000.

Some of the signficant activities of the campaign during the "awareness" year to focus on American Indian and Alaska Native youth are the recent leadership conference in Washington, DC, the upcoming Indian YOUTH 2000 day on September 28, 1988, and the development of a National Indian Youth Agenda by the end of the year where a role and function is defined for all levels --youth, tribe, Indian organizations, community, urban area, state, local, federal, etc.--that need to come together to comprehensively address and move to action to accomplish the goals the youth are setting for themselves by the year 2000.

I have some recommendations that I would like this Committee to seriously consider--recommendations that can positively affect the lives of Indian youth and really make a difference:

1. To actively support the formation of Tribal Youth Councils across Indian Country over the short term. Over the long term to provide seed funds to enable them to carry out

their goals--the solutions they come up with after going through their own process of determining what their problems are.

2. To promote a UNITY national network of Tribal Youth Councils which would result in a collective national voice for American Indian and Alaska Native youth.
3. To ensure that Indian youth have a voice at every level from the local to the national and that they be represented at all Congressional and other hearings which affect their future and well being.
4. To help UNITY establish the Institute for Leadership Training for American Indian and Alaska Native Youth to put in place a permanent mechanism for the long term training for Indian youth--such as monthly seminars and conferences on an ongoing basis.

   There is a vacant college campus in Oklahoma City which would be ideal as an ongoing leadership training facility. Tribes, Alaska Native communities and urban areas could send us their outstanding young men and women to receive intense leadership training so that they could then return to their respective communities and be prepared to "make a difference." They would receive the necessary motivation, training in communications skills, tribal governance, and other skills they need to truly make them the future leaders of Indian tribes and their communities.

5. To support or create a way to make a quick and positive impact on Indian Country right now through organizing all Indian athletic teams, such as basketball, that could travel to the various reservations and also conduct clinics for local youth. By example, these teams would help build self esteem and encourage youth to avoid alcohol and drug use. It would obtain pledges from the local youth to not abuse alcohol, drugs and other substances. This would also have an impact upon encouraging the youth to strive harder--both on and off the courts and fields. This would also serve to encourage local youth to earn spots on varsity teams.

Mr. Chairman, thank you for the opportunity to present these facts and ideas to you and your Committee--we know we can count you in to help us make a difference.

J. R. Cook
Executive Director

United National Indian Tribal Youth, Inc.

UNITY

THE VISION

UNITY envisions an America in which the American Indian and Alaska Native population is no longer near the top in every negative social condition--poverty, unemployment, alcoholism, low self image, education drop-out rate, infant mortality rate, incarceration in penal institutions and training schools, poor health conditions, inadequate housing, suicidal tendencies, and discrimination.

UNITY envisions Indian people who are very proud of the accomplishments of their ancestors and who are maintaining the best of their traditions, but who are more concerned about the present and the future than in trying to relive the past.

UNITY envisions strong individuals who feel good about themselves, about being American Indian and Alaska Native, about being alive at this particular time in history.

UNITY envisions Indian youth strengthening their own individual lives, which in turn will strengthen their respective Tribes, their communities, which in turn will strengthen the American Indian and Alaska Native people as a whole, which in turn will strengthen the human race.

UNITY envisions a more self-sufficient people--doing all they can for themselves instead of looking to the federal government or some other source to solve all the problems and to provide for every need.

UNITY envisions Indian and Alaska Native youth excelling in their fields of choice and successfully competing in every facet of life--whether in athletics, music, medicine, law, finance, industry, technical areas, and in every other field.

UNITY envisions young Indian men and women encouraging and supporting each other. The infighting, jealousies, factionalism, and negative peer pressure which currently exists will thus be eliminated.

The Vision....

UNITY envisions a spiritual renewal in which individuals will practice the faith which is most practical and meaningful to them and in which each individual respects the rights of others to worship as they please.

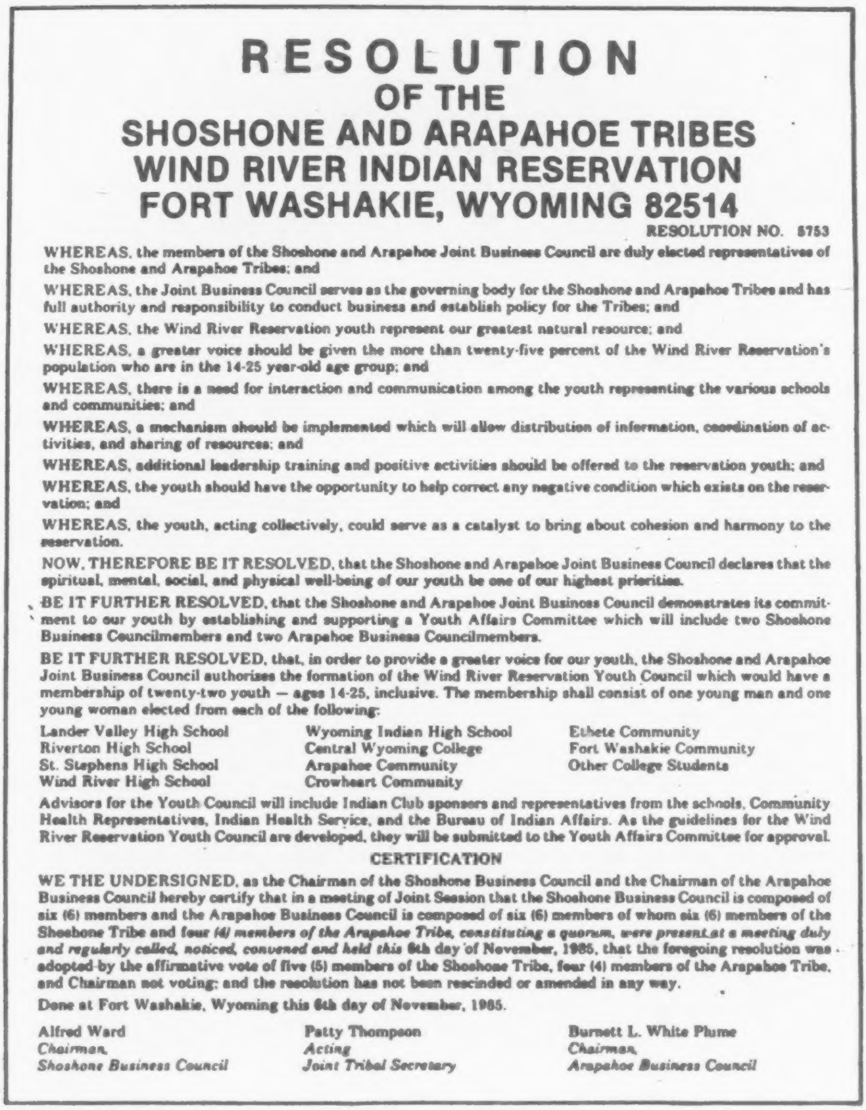
Since more than half the total American Indian population are under 25 years of age, the future of their race is at stake. Whether or not the respective tribes survive depends entirely upon the youth of today.

UNITY envisions today's young Indian and Alaska Native men and women accepting the challenge, rising to the occasion, and righting the wrongs which currently exist.

Yes, even though there will continue to be more diversity among Native American people than of any other ethnic group, UNITY ENVISIONS a strong, proud and united people.

And UNITY ENVISIONS the United National Indian Tribal Youth, Inc. to be that strong and effective organization which serves as a vehicle through which American Indian and Alaska Native youth come together, get acquainted, exchange ideas, and work cooperatively to build a great future for American Indian and Alaska Native people of all tribes.

Count me in
Youth 2000
UNITED NATIONAL INDIAN TRIBAL YOUTH



RESOLUTION
OF THE
SHOSHONE AND ARAPAHOE TRIBES
WIND RIVER INDIAN RESERVATION
FORT WASHAKIE, WYOMING 82514

RESOLUTION NO. 8753

WHEREAS, the members of the Shoshone and Arapahoe Joint Business Council are duly elected representatives of the Shoshone and Arapahoe Tribes; and

WHEREAS, the Joint Business Council serves as the governing body for the Shoshone and Arapahoe Tribes and has full authority and responsibility to conduct business and establish policy for the Tribes; and

WHEREAS, the Wind River Reservation youth represent our greatest natural resource; and

WHEREAS, a greater voice should be given the more than twenty-five percent of the Wind River Reservation's population who are in the 14-25 year-old age group; and

WHEREAS, there is a need for interaction and communication among the youth representing the various schools and communities; and

WHEREAS, a mechanism should be implemented which will allow distribution of information, coordination of activities, and sharing of resources; and

WHEREAS, additional leadership training and positive activities should be offered to the reservation youth; and

WHEREAS, the youth should have the opportunity to help correct any negative condition which exists on the reservation; and

WHEREAS, the youth, acting collectively, could serve as a catalyst to bring about cohesion and harmony to the reservation.

NOW, THEREFORE BE IT RESOLVED, that the Shoshone and Arapahoe Joint Business Council declares that the spiritual, mental, social, and physical well-being of our youth be one of our highest priorities.

BE IT FURTHER RESOLVED, that the Shoshone and Arapahoe Joint Business Council demonstrates its commitment to our youth by establishing and supporting a Youth Affairs Committee which will include two Shoshone Business Councilmembers and two Arapahoe Business Councilmembers.

BE IT FURTHER RESOLVED, that, in order to provide a greater voice for our youth, the Shoshone and Arapahoe Joint Business Council authorizes the formation of the Wind River Reservation Youth Council which would have a membership of twenty-two youth — ages 14-25, inclusive. The membership shall consist of one young man and one young woman elected from each of the following:

Lander Valley High School
Riverton High School
St. Stephens High School
Wind River High School
Wyoming Indian High School
Central Wyoming College
Arapahoe Community
Crowheart Community
Ethete Community
Fort Washakie Community
Other College Students

Advisors for the Youth Council will include Indian Club sponsors and representatives from the schools, Community Health Representatives, Indian Health Service, and the Bureau of Indian Affairs. As the guidelines for the Wind River Reservation Youth Council are developed, they will be submitted to the Youth Affairs Committee for approval.

CERTIFICATION

WE THE UNDERSIGNED, as the Chairman of the Shoshone Business Council and the Chairman of the Arapahoe Business Council hereby certify that in a meeting of Joint Session that the Shoshone Business Council is composed of six (6) members and the Arapahoe Business Council is composed of six (6) members of whom six (6) members of the Shoshone Tribe and *four (4) members of the Arapahoe Tribe, constituting a quorum, were present at a meeting duly and regularly called, noticed, convened and held this* 6th day of November, 1985, that the foregoing resolution was adopted by the affirmative vote of five (5) members of the Shoshone Tribe, four (4) members of the Arapahoe Tribe, and Chairman not voting; and the resolution has not been rescinded or amended in any way.

Done at Fort Washakie, Wyoming this 6th day of November, 1985.

Alfred Ward	Patty Thompson	Burnett L. White Plume
Chairman,	*Acting*	*Chairman,*
Shoshone Business Council	*Joint Tribal Secretary*	*Arapahoe Business Council*

RESOLUTION
OF THE
UTE INDIAN TRIBE
UINTAH AND OURAY RESERVATION
FORT DUCHESNE, UTAH 84026

WHEREAS, the youth of the Uintah and Ouray Reservation represent our greatest natural resource, and

WHEREAS, a greater voice should be given the more than twenty-five percent of the reservation population who are in the 14-25 year old group, and

WHEREAS, the youth of the Uintah and Ouray Reservation will one day determine the future of the Ute Indian Nation and surrounding economics, and

WHEREAS, additional leadership training and positive activities should be offered to the youth to develop their natural talents and potential, and

WHEREAS, the youth should have the opportunity to help correct any negative conditions which may exist on the reservation, and

WHEREAS, the youth, acting collectively, could serve as a catalyst to bring about more cohesion and harmony to the reservation.

NOW, THEREFORE, BE IT RESOLVED BY THE UINTAH AND OURAY TRIBAL BUSINESS COMMITTEE OF THE UTE INDIAN TRIBE that they declare that the spiritual, mental, social and physical well-being of our youth be one of our highest priorities.

BE IT FURTHER RESOLVED, that the Uintah and Ouray Tribal Business Committee demonstrate its commitment to youth by establishing and supporting a Youth Affairs Committee composed of at least one representative from every department affecting youth programs to ensure the support, cooperation, and coordination of all efforts to enhance youth activites. The Chairman of this Committee will be selected by said Committee and will be responsible to the Committee. Interested individuals, BIA and IHS Employees are encouraged to be members of said Committee by invitation of the same. Administsrative Leave will be granted to all Tribal Employees who are members of the Committee for authorized meetings.

BE IT FURTHER RESOLVED that in order to provide a greater voice for our youth and give them greater opportunities to participate in tribal leadership, the Uintsh and Ouray Business Committee authorizes the formation of a reservation-wide youth council to represent all Indian youth. This organization will operate under the supervision, support and encouragement of the Youth Affairs Committee.

seattle indian health board

Testimony before the
SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
on a
COMMUNITY MENTAL HEALTH INITIATIVE

Presented by:

JoAnn Kauffman

Executive Director, Seattle Indian Health Board and
President, National Association for Native American
Children of Alcoholics

July 7, 1988

Washington, D.C.

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seattle, washington 98114

area code 206
324-9360

Mr. Chairman:

My name is JoAnn Kauffman. I am an enrolled member of the Nez Perce Tribe of Idaho. I am currently the Executive Director of the Seattle Indian Health Board, a board member of the American Indian Health Care Association and a founding board member of the National Association for Native American Children of Alcoholics. I hold a Masters degree in Public Health Administration and I have been directly involved in the delivery of health and mental health services to Indian communities since 1972, when I first directed the American Indian Mental Health New Careers Training Program in Minneapolis, Minnesota.

As an advocate and organizer of Indian health services I have seen the way in which resources are structured for Indian communities in both reservation and urban settings. Over the past sixteen years, I have observed the following to be true:

1. The Indian Health Service was founded on a "medical" model program and maintains this basic clinical structure in its operations.

2. The Indian Health Service has been extremely successful in its attack on such health problems as tuberculosis, maternal mortality, infant mortality and other problems which respond to clinical intervention.

3. The Indian Health service has not been particularly effective nor creative in dealing with health problems which exist outside the clinical structure such as alcoholism, substance abuse, domestic violence, suicide, homicide, accidents, sexual abuse or mental problems.

4. The Indian Health Service today does not exhibit the commitment nor enthusiasm needed to substantially increase its mental health initiatives in Indian communities, nor does it appear willing to let go the medical model of operation without Congressional encouragement.

5. The Bureau of Indian Affairs while representing a significant role in Indian communities has shown very little interest in mental health despite its responsibility to provide social services, law enforcement and child protection.

6. Territorial battles among the employees who protect their professional disciplines will need to be addressed and overcome for an effective comprehensive community-

based mental health initiative to be achieved in Indian country.

7. Indian mortality today is largely a result of lifestyle behavior and the exposure to those related risks. Indian wellness is dependent upon a comprehensive support system which can address personal, family, tribal and community-wide recovery and support for healthy behavior.

With those major points set out, I would like to discuss in more detail factors needing to be addressed in a comprehensive community-based Indian mental health initiative.

Mental Health and Mental Illness

The term "mental health" often carries with it a stigma of "mental illness." This is particularly true when the resources targeted toward "mental health" have been so miniscule that these services are limited to only the "severely or chronically mentally ill."

In Washington State the only resources available to provide mental health services to low income urban Indians comes from the State government. A strong State lobby primarily made up of relatives of deinstitutionalized mentally ill persons has successfully fought for restriction of State resources for the deinstitutionalized population. While there are certainly a proportionate number of Indians who fall under this definition there are many more Indians in need of mental health counseling who do not fit a definition of mentally ill. An example often given in our State is a case of a woman with a history of child sexual abuse who seeks counseling but finds she is not eligible under the mentally ill definition. If she attempts suicide, however, she would then qualify for services as "severely mentally ill." This system locks out opportunities to promote mental health.

Dr. Candace Fleming, a researcher at the National Center for American Indian and Alaska Native Mental Health Research in Denver, Colorado, points out that the psychiatric disorders perported to be higher in Native Americans are primarily "depression and anxiety," but the pattern of symptomotology might not be recognized clinically and instead seems to be pervasive across the community and multi-generational in scope.

Indian mental health and Indian mental illness are not areas to be plugged by the traditional psychiatric/clinical approach. A fundamental premise of mental health and mental wellness must be made for a comprehensive community-based initiative.

Cultural Oppression and Cultural Depression

While aggression against Indian culture is well documented in American history books, far too little has been discussed concerning its multi-generational effects on the mental status of Indian people today. Jane Middelton-Moz, Native American psychologist in Washington state, has completed extensive research on "cultural depression" and found that there are two major areas effecting Native Americans today. The first is the effects of the stigma and depression caused by forced acculturation. She states "One Native woman I worked with in urban Seattle had previously been through five inpatient and three outpatient alcoholism programs. Evaluations I received indicated that she was 'resistant to treatment.' As well as being diagnosed as "alcoholic", she also carried the diagnosis of "antisocial personality disorder," "hystrionic personality disorder," and "battered woman syndrome." Her use of alcohol and drugs began when she entered a white school system off her reservation in the seventh grade. She stated that this was the first time she relized that she was "stupid." She talked about being teased constantly in school and felt bad about herself, which she had never felt before. Both of her parents were alcoholic, but she said that she had always been cared for by her aunts and grandparents when her parents were drinking. She felt her childhood had been happy. Her grandmother had taught her the strengths and values of native culture, but she had often felt confused because her parents had never reinforced those values and seemed to feel "shame" at being Indian. She left the reservation when she was 18 to get a job in the city. She said she liked being with people and always let people who didn't have a place to stay or the money for housing stay with her. She was often confused when they would steal from her to beat her up, but said that she couldn't say "no" when someone was homeless. She had tried to kill herself once when she was drunk and consequently entered treatment. The only Indian in the treatment program, she felt alone and didn't understand what was being taught. She said she felt stupid, as she had felt in school.

Another woman with a similar experience told me, "My grandmother taught me that the heart tells you what to do and you should always listen to your heart for its lessons. Then you learn in school that your head should tell you what to do. The mind tells you something - that the heart is not the way white people tell you to be. It's really confusing."

Throughout treatment, neither of these women had been asked about the values they had learned in their culture, the strengths they felt concerning those values, or their confusion; neither had been asked about their grief concerning early education experiences or of the grief they felt in their parents; neither had been asked about their kinships network, the experiences of reservation life; and neither, even though one woman lived with her family on the reservation, had been asked to take part in family treatment.

Treatment programs designed in separation from the culture often ignore the grief and depression resulting from acculturation, the effects of stigma on the culture, as well as ignoring one of the most powerful tools in the healing process, the strength of the values of Native American and Alaskan people. Often not considered as well, is the powerful impact of peer pressure on the native person. Programs which remove the individual from his/her kinship network are destined to make statistics a self-fulfilling prophecy.

Attached to this testimony is a copy of a 1923 memo from the Commissioner on Indian Affairs to the Indians of the United States which prohibits the open practice of Indian dances, ceremonies, feasts, give-aways or other such cultural/spiritual activities, and threatens the removal of basic survival tools (food and shelter) unless these rules are followed. This committee has undoubtedly heard accounts of Indian children beaten for speaking their language in early government and religious boarding schools. The Christian missionary campaign worked hand in hand with the federal government at the turn of the century to stamp out the remnants of organized Indian religion and its leadership and, in effect, drove underground traditional spiritual practices.

The effects of cultural oppression are multi-generational. We cannot presume that the entirety of the physical, emotional and spiritual trauma experienced by our grandparents have gone to the grave with them. On the contrary, a legacy of unresolved grief exists with us today.

Indian people who have grown up in communities with cultural depression receive mixed and often contradictory messages about their Indian-ness:

- Be proud of your heritage.
- Leave this reservation if you want to become somebody.
- Get a good education and come back and help your people.
- We can't hire an Indian person to run our program; we need a white person to do the job right.
- I could never work for my own tribe; they're too crazy.
- Shame on you for not knowing your own language.
- We don't talk about our beliefs in public. You shouldn't ask.
- He's just a heathen.

Cultural depression follows cultural oppression for the next generation and the next until the cycle is broken. Cultural depression is anger turned inward, hatred turned toward ourselves, toward our own people, toward our own identity as Indians. In a national demonstration program funded by the Office of Minority Health to break the cycle of addictions among Indians in Seattle and with the ten Puget Sound tribes, it was discovered that in addition to the family dysfunctions caused by alcoholism and its abuse, participants in our project also described cultural depression as a major factor in their childhood and one which needed resolution.

Anna Latimer, M.A., director of this demonstration project, describes the significance of cultural depression and Indian mental health as follows: In our program, we have found that the effects of cultural oppression are equal to, if not more than the devastating effects of multigenerational alcoholism among Native Americans. Among the ten tribes and three urban agencies, cultural oppression has shown iself in the form of shame. "Shame is the inner experience of being looked down upon by the social group. It is the self judging the self. A moment of shame may be humiliation so painful or an indignity so profound that one feels one has been robbed of his or her dignity or exposed as basically inadequate, bad or worthy of rejection. A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, defective, unworthy, or not fully valid as a human being. (Facing Shame, page 5, Fossum and Mason. 1986).

We found that this pervasive sense of shame impacts an individual on many levels. Comments such as, "I've never felt worthy", "I can't deal with positive attention from the group", "I was afraid you would find out how inadequate I am", "I tried to kill myself because everybody thinks I'm just not worth anything" continue to be shared in support groups.

The pain runs very deep for many of us. It is rooted in abuse, personal violations, seductions and assaults where one's sense of self has been trampled, one's boundaries defiled. The absense of an affirmation of self is rampant among ourselves, our children and our communities. If we are unable to affirm ourselves as human beings, then a pervasive sense of cultural self-hate develops. It is this that we must bring to the forefront of our awarensess and our hearts. In our program, we are just now identifying this phenomenon among ourselves. It is of utmost importance that clinical recognition of cultural self-hate as a family dynamic among Native Americans be addressed by mental health professionals and agencies. If not, we will continue the cycle of pain from the double-edged sword of alcoholism and cultural self-hate.

Alcoholism, Family Dysfunction and Its Multi-Generational Cycles

A "dysfunctional family" is one in which the primary focus of that family is on something other than the nurturing and wellness of its children. In a family with alcoholism the attention is focused on the alcoholic. The spouse covers up for the alcoholic; the older children take care of the feeding, finances and management of the family; the younger children often "act out" as juvenile delinquents to draw attention from the alcoholic or perhaps to give the family another addict to take care of if the parent is in recovery. In alcoholic families the children learn at a very early age that their needs are not important.

"Denial" by the alcoholic that there is anything wrong and the support for that denial from family members creates a home environment where children learn to not trust their own thoughts, feelings and perceptions. A common early experience for many children of alcoholics is to come home and find for the first time a parent passed out on the floor. "Is she dead?" "No, she's fine," the adults tell the child. "Go play."

The majority of all Indian children today are growing up in homes where one or both parents are actively involved in alcoholism or some other addiction. Children who grow up in alcoholic families learn these three basic rules for survival:

- Don't trust.
- Don't talk.
- Don't feel.

These rules set the stage for other childhood traumas such as incest, sexual abuse, battering, neglect and abandonment. Research by Robert Ackerman has found that children of alcoholics experience much higher rates of physical and sexual abuse and they are less likely to report it.

Child sexual abuse is involved in 30-50% of all the Indian Child Welfare cases reported out of the Seattle Indian Unit of the State's Child Protection Services. Yet, there are no Indian-specific mental health counseling resources with the adequate capacity to meet the needs of these children and their families. Child abuse is drastically under-reported in Indian country, particularly child sexual abuse.

Dr. DeeAnn DeRoin, a physician at Haskell Indian College, presented her findings on Indian child abuse last year, and found that, while the rate of total reported cases of abuse for Indian children was less than the rate of report for the general public, the rate of actual convictions for Indian abuse cases far exceeded the rate of convictions for cases reported in the general public. This suggests that Indian child abuse is only being reported in those gross, undeniably apparent situations, and that suspected cases of abuse are largely going unreported.

The effects of alcoholism, violence and family dysfunction on the children places them at risk for social isolation, school drop-out, alcoholism, drug abuse, depression, low self esteem, promiscuity, self destructive behavior, suicide and a very high likelihood that, left untreated, they will repeat this cycle of dysfunctional behavior with their own children.

Except for a small handful of community-based efforts, there is not now an initiative aimed at healing the emotional pain of multi-generational family dysfunction and breaking this cycle in Indian communities.

Denial Within the System

A traditional spiritual leader of the Suquamish Tribe, Harold Belmont, often asks "Who heals the healers? Who cares for the caretakers?" Given what I have described in this testimony about the pervasive multi-generational depression [the adults] who have grown up in alcoholic homes and the rates of chemical abuse in Indian country, it is likely there are many Indian people in the business of providing services to Indians who will benefit from intensive training on the comprehensive spectrum of Indian mental health, not simply for intellectual or professional storage, but for personal healing and recovery.

An Indian mental health system cannot simply segregate "those with pathology" and "those with professional degrees." Such a model undermines the premise and desired outcome of a comprehensive community-based initiative. Promoting such a medical model is a powerful and sophisticated mechanism of "denial" that needs to be broken down. IHS and BIA officials, tribal councils, teachers, child welfare workers, social workers, and others who are helpers to Indian people and who will play a vital role in a community-based mental health effort MUST BE HEALTHY. The initiative must begin with those who will implement it.

Multidisciplinary Approach

There exists a tremendous resource to promote a community mental health initiative among the various agencies involved in Indian communities. A prerequisite to mobilizing this resource is to establish a commitment of cooperation and to provide the necessary training of staff so that a common framework of information around Indian mental health is set. These resources include IHS medical staff, IHS mental health staff, BIA social services and law enforcement staff, Indian child welfare workers, educators, religious leaders, traditional spiritual leaders, tribal employees, alcoholism treatment staff and other community helpers.

Breaking through community denial is the first step toward developing this multi-disciplinary team. An experiential training model similar to that utilized in the Seattle ACOA Project or the Flathead Reservation's Blue Bay Healing Center is important toward setting the community initiative.

A continuum of recovery is important to this model. For example, after treatment for alcoholism or substance addiction, other mental health related issues arise which can either be addressed or allowed to fester and become a source for relapse. These include counseling and support for survivors of child sexual abuse, anger management, relationship counseling, spiritual development and support for children of alcoholics issues.

Adequate resources are needed so that Indian communities can provide these support systems for personal recovery of its members and for the community as a whole.

Recommendations

1. That a multidisciplinary comprehensive community-based mental health initiative be undertaken by this Committee and that the Indian Health Service and BIA be directed to participate with Indian communities on this initiative.

2. That this Committee adopt a definition of community mental health which is not restricted to the clinical model and one which promotes wellness and incorporates the notion of physical, spiritual, mental and emotional balance.

3. That this Committee investigate the effects of multi-generational cultural oppression, alcoholism, domestic violence, and family dysfunction as it relates to the status of Indian mental health today.

4. That this mental health initiative assess in particular the needs of the following groups:
    a. Child sexual abuse: individual and family mental health care for the victim, perpetrator and family members.
    b. Adult children of alcoholics: education, information, support groups and individual therapy for adult children of alcoholics to begin recovery and help break the cycle of addiction.
    c. Young children of alcoholics: education and information campaign for children living in alcoholic homes to provide support and therapy.
    d. Elderly: support for the unique needs of Indian elderly in dealing with alcoholism and early mortality of family members.
    e. Dual diagnosis: provide case management services for individuals with both chemical addictions and mental illnesses to assure appropriate care.
    f. AIDS: to provide individual counseling and support groups for Indians with AIDS, for their family members and others who must deal with the inevitable losses around this disease.

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DEPARTMENT OF THE INTERIOR
OFFICE OF INDIAN AFFAIRS
WASHINGTON

A Message

TO ALL INDIANS:

Not long ago I held a meeting of Superintendents, Missionaries and Indians, at which the feeling of those present was strong against Indian dances, as they are usually given, and against so much time as is often spent by the Indians in a display of their old customs at public gatherings held by the whites. From the views of this meeting and from other information I feel that something must be done to stop the neglect of stock, crops, gardens, and home interests caused by these dances or by celebrations, pow-wows, and gatherings of any kind that take the time of the Indians for many days.

Now, what I want you to think about very seriously is that you must first of all try to make your own living, which you cannot do unless you work faithfully and take care of what comes from your labor, and go to dances or other meetings only when your home work will not suffer by it. I do not want to deprive you of decent amusements or occasional feast days, but you should not do evil or foolish things or take so much time for these occasions. No good comes from your "give-away" custom at dances and it should be stopped. It is not right to torture your bodies or to handle poisonous snakes in your ceremonies. All such extreme things are wrong and should be put aside and forgotten. You do yourselves and your families great injustice when at dances you give away money or other property, perhaps clothing, a cow, a horse or a team and wagon, and then after an absence of several days go home to find everything going to waste and yourselves with less to work with than you had before.

I could issue an order against these useless and harmful performances, but I would much rather have you give them up of your own free will and, therefore, I ask you now in this letter to do so. I urge you to come to an understanding and an agreement with your Superintendent to hold no gatherings in the months when the seed-time, cultivation of crops and the harvest need your attention, and at other times to meet for only a short period and to have no drugs, intoxicants, or gambling, and no dancing that the Superintendent does not approve.

If at the end of one year the reports which I receive show that you are doing as requested, I shall be very glad for I will know that you are making progress in other and more important ways, but if the reports show that you reject this plea, then some other course will have to be taken.

With best wishes for your happiness and success, I am

Sincerely yours,

Commissioner.

February 24, 1923.

Ethnic Minority Mental Health in the late 80's: Problems and Proposed Solutions

Sheppard Salusky

Scattle Indian Health Board

Running Head: Minority Mental Health

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Abstract

Ethnic minorities have struggled to obtain adequate mental health care. Mental health providers, closely tied to ethnic minority communities, have examined the elements involved in the delivery of adequate services to minority clients. These assessment and treatment issues are briefly reviewed and discussed. In the last several years, the ethnic minority communities of King County, Washington have developed and implemented culturally sensitive mental health services. A close look however at need and utilization statistics indicate that King County service delivery to ethnic minorities remains inadequate. The situation would improve dramatically if minority mental health clinics, established by ethnic communities, were provided with adequate funds. These clinics would offer much better services if permitted to set their own service goals and priorities.

Minority Mental Health

Historically, ethnic minority communities have been unable to obtain adequate mental health services. Studies in the 70's by Sue and colleagues (Sue 1976, Sue 1977, Sue & McKinney 1975, Sue, Mckinney Allen & Hall, 1974) demonstrated the appalling lack of adequate mental health services to ethnic minority clients in King County, Washington. As Sue published his work, the ethnic minority communities in King County created their own mental health clinics separate from those designed to serve distressed majority clients. In cooperation, these minority clinics continue to develop and expand services to the minority communities in and out of King County. These minority clinics have learned well the ways in which mainstream mental health must be altered to provide effective services. The minority mental health issues and concerns that face King County providers parallel those that have been articulated in the psychological literature.

Researchers associated with ethnic minority communities agree on the general nature of good ethnic minority mental health. Services must be tailored to the specific community served. These unique services must be in adequate supply, and utilization must be commensurate with need.

Assessment

Rogler, Malgady, Constantino and Blumenthal (1987) note that services most likely to be effective are those that have been modified to fit the culture. Unfortunately, no commonly used assessment devices meet this criteria. Lopez and Nunez (1987), for example, reviewed the 11 most frequently used clinical and research assessment tools. The review included the Diagnostic and Statistical Manual, Third Edition (DSM-III); the Diagnostic Interview Schedule (DIS); the Schedule for Affective Disorders and Schizophrenia (SADS); the Structured Clinical Interview for DSM-III; the Structured Interview for DSM III Personality Disorders; and several other instruments. 8 of the 11 include at least one item related to culture. These items are used primarily to prevent the application of a diagnosis based on behaviors that are pathological in the majority culture but normal in the minority group. Two instruments assume a universal set of diagnoses can be applied across cultures. Westermeyer (1987), a proponent of the position that there are no culturally unique psychiatric disorders, contends that at least some DSM-III diagnoses can be obtained across some cultures with adequate and accurate information.

Sue and Sue (1987) take the position that diagnosis is more culture bound. They reviewed the literature that supports the notion that Asian Americans report psychological distress in somatic terms. Sue and Sue note that DSM-III requires dsyphoric mood for the diagnosis of depression. This requirement would exclude many depressed Asian Americans. DSM-III-R does permit the diagnosis of major depression without report of dysphoric mood if anhedonia is present. Still, it would be quite difficult to obtain a diagnosis of major depression based solely on somatic symptoms in DSM-III-R. On the other hand, the Hamilton Rating Scale for Depression (HRSD) does include a broad range of somatic symptoms. This instrument might be better suited for the diagnosis of depression with Asian Americans. Unfortunately, it would diagnose as depressed many Asian Americans suffering from other conditions.

A proponent of universal diagnosis might argue that Asian Americans who report somatic symptoms should receive a somatoform diagnosis. Though this might eliminate the problem of diagnosis, it obscures treatment. The proper treatment for an Asian American who expresses depression through somatization might differ dramatically from the treatment of a caucasian who carries a true somatoform disorder diagnosis. Since diagnosis implies treatment, this situation defeats a primary function of diagnosis.

There are similar problems with psychological assessment. Pollack and Shore (1980) obtained extremely pathological MMPI profiles on 142 Pacific Northwest Indians. Pollack and Shore contend that the MMPI cannot be used in a standard fashion with American Indians. Their data indicate that the overall elevation of the profile, rather than the combination of elevations and scale relationships, distinguish diagnostic groups. With caucasians, the relationships between the various clinical scales are often at least as important as the elevations on each scale.

Butcher, Braswell and Raney (1983) present data on 36 American Indian, 97 Black and 454 White psychiatric inpatients hospitalized in Minnesota. Minority subjects were matched with Whites on gender, occupational status and social class. It is important to note subjects were not matched for diagnosis.

The authors argue that their American Indians are less pathological than the Black and White samples. This interpretation is less than convincing without evidence that the Indian sample is indeed less distressed than the other groups. Butcher et al. report results that conflict with their interpretation. Seven pathology related variables are examined. Only three are significantly different. On one, Indians are more distressed than Blacks. It is important to note that diagnosis was not significantly different among the ethnic groups. Further, the relationships between these seven pathology related variables (eg, diagnosis) and MMPI scores were not explored. As Greene (1987) notes, this is essential to any meaningful interpretation of ethnicity and the MMPI.

The problem becomes obvious when the diagnoses from Pollack and Shore are considered with the Butcher et al. results. The Indian MMPI means in these two studies are similar. Butcher et al. might have us apply conventional MMPI wisdom to the Pollack and Shore data. If this suggestion is followed, any of a number of resources (eg, Greene, 1980; Lachar, 1974; Marks, Seeman and Haller, 1974; Graham, 1977), would diagnose as paranoid schizophrenic Pollack and Shore's nonpsychotic Indians. Relationships between test scores and symptom related variables must be explored before it will possible to use the MMPI in any meaningful way with minority clients. Unfortunately, this is a costly and complex venture.

Jones and Thorne (1987) propose an alternative to empirical assessment approaches with ethnic minority clients. They argue the client's experience must be understood, that the client must be seen as a collaborator in a joint venture. Culture is one important aspect of the client's experience. In their view, empirical approaches that seek to examine the client as object often fail to obtain the relevent information.

Whether assessment is approached from a behavioral, psychoanalytic, empirical or phenomenological framework, diagnosis and assessment may be compromised if culture is not specifically addressed. At the Seattle Indian Health Board, we are developing assessment approaches that are sensitive to the variety of Native American cultures. It is expected that well trained and experienced clincians working in the context of an American Indian clinic will be able to use these assessment approaches to obtain more useful evaluations.

Treatment

After an accurate assessment has been obtained, it becomes possible to deliver adequate treatment. As Sue and Zane (1987) seem to realize, it is extremely difficult to prescribe a formula for the treatment of minority clients. Earlier efforts to detail cultural differences have not been used effectively by mental health facilities. The "cookbook" approach may have exacerbated an already difficult problem. They note the individual must be considered both in the context of culture and as an individual. Special attention is paid to two elements, credibility and giving. Sue and Zane describe therapy in a way that is similar, in many respects, to the subjective approach of Jones and Thorne (1987).

For minority clinicians who work in an agency controlled by the community served, it is relatively easy to implement these principles. Majority clinicians, in minority agencies, who seek to work with minority group members must acquire sufficient cultural knowledge to provide effective services. Westermeyer (1987) encourages the committed clinician to live for two years in the culture. The problems multiply rapidly when majority agencies seek to serve minority clients.

In majority agencies, even ethnic minority clinicians will find it difficult, if not impossible, to provide adequate services to members of their own group. The structure of majority institutions can pose a formidable obstacle to effective service delivery. In a culturally sensitive program within a majority institution, decisions must be approved by a majority administrative struture. To use an American Indian example, there are few mental health administrators who could effectively apportion scarce resources between sweats, talking circles, traditional crafts, family and individual treatment. Without the proper balance of services and programs, efficacy is compromised. Further, few administrators would know how to recruit Indians with the expertise to provide these activities. Even if a pool of applicants could be obtained, few majority administrators would be able to evaluate the candidates abilities to provide these special services.

Clinical supervision is equally complex. Sutton and Kessler (1987) found that clinical psychologists judged clients more negatively if the client was perceived to be from a lower social class. This tendency could interact with lack of knowledge about some of the more signficant differences between the many minority cultures represented in the clinic. The synergistic effect of these two factors could potentially lead to destructive clinical decisions. Clinical supervision might also suffer, as ethnic minority supervisees struggle unsuccessfully to obtain useful comments on the therapeutic process.

For the minority client, mainstream mental health clinics may be unacceptable. At the Seattle Indian Health Board, many of our clients refuse to accept referrals to mainstream clinics for specialty services unavailable at our facility, even when those mainstream clinics employ minority clinicians. Informal discussions with other minority agencies indicate comparable issues with other minority groups. In many cases, minority clients first sought services at majority agencies but found the treatment inadequate. In other cases, minority clients will not seek services at majority agencies for fear that more harm than good will result. O'Sullivan, Peterson, Cox and Kirkeby (1987) note a substantial increase in mental health services to ethnic minorities in King County in the last decade. It is likely that the increase is due almost exclusively to the efforts of the King County minority mental health agencies. These clinics have won the trust and respect of their communities. Without minority agencies that are independent from mainstream providers, service provision to ethnic minorities might deteriorate to the levels observed in the 60's.

Need

In King County, the minority mental health clinics provide a wide range of specialized services to minority clients. The existence of culturally sensitive mental health services is perhaps the most important, but not the only component, in an effective minority mental health system. These services must be available in quantities sufficient to meet the community needs. The estimation of need is a difficult problem that will be discussed in this section. Several indices of need will be examined.

A very rough estimate is the time a client must wait to receive services. In 1987, the Seattle Indian Health Board maintained a waiting list that varied from 3 to 16 weeks. Additional funds would permit the agency to hire the staff necessary to decrease the wait. Though the demand for mental health services exceeds the supply, this does not prove that the available supply is insufficient. It is possible many who request services do not really need them. Other indices of need will illuminate this issue.

Insert Table 1 and Table 2 about here

Tables 1 and 2 display data on two other potentially important indices of need. Referrals to Child and Protective Services (CPS) are made on people suspected of child abuse. It is reasonable to assume that the majority of these people are in need of mental health treatment. Involuntary treatment is another measure of need. Less extreme approaches either were not available to the client or proved ineffective. In this sense, involuntary treatment cases are an indication of need, not a measure of treatment provided.

Chi Square analyses (Edwards, 1972) reveal a clear trend. In 1986, there were significantly fewer than expected statewide CPS reports on Whites, Asians and "Others." Blacks, Native Americans, and Hispanics were reported at a higher than expected rate. In 1986, significantly fewer than expected Whites were involuntarily treated in King County. More Blacks and Hispanics were involuntarily hospitalized than expected. Similarly, fewer Whites, Asians and "Others" were investigated than expected. Significantly more Blacks and American Indians were detained but not hospitalized.

On these two indices, Whites are less likely than expected to become invovled with the state emergency system. Other minority groups are more likely than expected to receive these services. Asians and "others" are the exceptions to this pattern. "Others" probably include some people who would be classified as White by Census criteria. Consequently, no effort will be made to interpret "other" data.

Is the finding for Asians really anomolous? As noted above, Sue and Sue (1987) contend that Asians are often assessed inaccurately. This could lead to fewer CPS and involuntary treatment referrals.

These data support the hypothesis that, in general, need is greater in minority communities than in the majority culture. Whites, with greater economic resources, are better able to obtain expensive but effective mental health services that will prevent the catastrophes that lead to intervention by the state emergency systems. Minorities must experience these catastrophes because there is an insufficient quantity of culturally sensitive mental health services available.

Though these indices are illuminating, additional information would permit a more definitive evaluation of the hypothesis presented above. Unfortunately, ethnic CPS data is only available for the entire state. In 1988, the King County judicial system will begin to track the ethnicity of court cases referred for mental health services. This is an important step, but it will not provide a complete set of data. For example, South Asians are not tracked separately from Asians. Indeed, some agencies surveyed by the Washington South Asian Council (1987) confused South Asian cultures with Southeast Asian cultures. It is extraordinarily difficult to assess culturally relevent needs when the relevent culture is not correctly identified.

Utilization

The data presented above suggests ethnic minorities have a greater need for mental health resources than Whites. It might also be expected that the quantity of available culturally sensitve services is insufficient. After all, if minorities received adequate services, they would not be overrepresented in CPS and involuntary treatment cases. Yet, O'Sullivan, Peterson, Cox, and Kireby (1987) found minorities to be overrepresented in the King County mental health system. They compared the number of community mental health center clients for each ethnic group to the number of people in each ethnic group in the county. They found less Whites use the community mental health system than would be expected based on the number of Whites in the general population. They also found minorities used CMHCs more than would be expected based on the number of minorities in the general population (see Tables 3 and 4). It is curious that some evidence suggests ethnic minorities have a greater need for mental health services whereas one report contends ethnic minorities receive a disproportionate share of services. This discrepency is worthy of further consideration.

Insert Tables 3 and 4 about here

Whites who can afford private mental health services will purchase them. This removes Whites with substantial incomes from those who seek, or need, CMHC services. A smaller proportion of ethnic minority consumers can afford private mental health services. Those relatively wealthy ethnic minorities who can purchase private services may seek treatment at minority mental health agencies because of the paucity of culturally sensitive services in the private sector. The impact of these effects may be assessed by comparing CMHC clients with their income matched counterparts in the general population.

Insert Table 5 about here

Table 5 displays the O'Sullivan et al. data with income modifications. In the first section, clients with incomes less than $6,000 are compared to an estimate of the King County population of persons with incomes less than $5,000. Unfortunately, it is not possible to match income groups precisely because O'Sullivan et al. report incomes in catagories that are incompatible with census data catagories. Population estimates are also difficult to obtain because O'Sullivan et al. report individual incomes instead of family or household incomes. Population estimates for the first section were obtained by finding the number of King County families for each ethnic group with incomes less than $5,000. For each ethnic group, this number was multiplied by the average number of people per King County poverty level family for that ethnic group. All population data for all three sections were obtained from Bureau of Census (1983).

The second section is comparable to the first. O' Sullivan et al. CMHC clients with incomes greater than $6,000 and less than $9,000 are compared with an estimate of King County residents with incomes between $5,000 and $9,999. Number of King County families in each ethnic group is multiplied by the number of people per King County poverty level family in that ethnic group, to obtain an estimate of the number of persons in each ethnic group with incomes between $5,000 and $9,999.

Section three is comparable to the other two. The only difference is the estimate of family size. Instead of using the poverty level multiplier for each ethnic group, families in each ethnic group were multiplied by the average number of people per family with incomes less than 125% of the poverty level for that ethnic group. This is a conservative estimate, since it may overestimate the number of Whites in the wealthiest sample.

The data is broken into three economic groups to illustrate the impact of economics on CMHC utilization. It is important to recognize that 69% of the CMHC clients fall into the lowest economic group. Consequently, the lowest income catagory most closely represents the CMHC utilization pattern in King County.

When income is considered, a clear trend emerges. In the lowest income group, Whites are significantly overrepresented. On the other hand, all ethnic minorities except Indians, Alaska Natives and Eskimos are significantly underrepresented. In the middle income group, Whites, Native Americans and Asians are overrepresented. This middle catagory may reflect the impact of a few Whites who can afford to purchase services outside the CMHC system. In the highest income group, Whites are underrepresented whereas all ethnic minority groups, except Hispanics, are overrepresented. This last income group may represent the impact of higher income Whites who have elected to purchase mental health services outside the CMHC system. On the other hand, relatively wealthy minorities, concentrated in the less affluent end of the range and faced with the absence of private culturally sensitive services, must rely almost exclusively on the CMHC system for mental health services. These data also support the hypothesis that ethnic minority clients receive fewer mental health services, at all income levels, than Whites.

Indians stand out as an exception to this trend. This seems curious, and remarkably inconsistent, since Indians have the lowest income of any ethnic group in the state. A closer look at the O'Sullivan et al. data reveals two significant problems that influence the interpretation of the results for all minority groups. First, services for Whites are geographically catchmented whereas services for minorities are not. Consequently, a White person who seeks mental health services must go to the CMHC in his area. A minority group member may seek services at the majority CMHC in her area, drop out of treatment, then seek services at her minority mental health agency. In short, O'Sullivan et al. may count minority group members multiple times. Whites are counted only once. The second problem is related to the first. Minority mental health agencies may see people outside King County. Majority mental health agencies do not accept clients outside the geographical catchment area. Consequently, the ethnic minority population eligible for services in King County is larger than the King County minority population. O'Sullivan et al. underestimate the minority population served.

Data from the Seattle Indian Health Board can be used to address both issues for Indians. It is likely that similar results would be obtained if comparable analyses were conducted with other minority groups. In the last two years, the Seattle Indian Health Board served over 15,233 patients in all departments (medical, pharmacy, optometry, dental, mental health, alcohol, nutrition, etc.) Of these patients, over 9540 were King County Native American residents. This represents 76.7% of the Indians in King County (O'Sullivan, et al. 1986). One could argue the Seattle Indian Health Board provides some service to all Indians who seek health care services in King County. However, a more conservative estimate will be used in subsequent calculations. It will be assumed that 100% of King County

Indians seeks health care services each year.

Data from the state information system and the Indian Health Board mental health department will be used to estimate services to King County Indians. In the calender year 1983, there were 283 referrals. This is probably a very rough estimate of counselor caseloads in 1983, since only about half of these referrals became cases, but a large number of cases in 1982 continued into 1983. Unfortunately, more accurate data for 1983 is not available. Better estimates can be obtained for 1986-1987. The Washington Community Mental Health Information System (CMHIS) indicates there were 162 Indian cases active at the Seattle Indian Health Board between January 1 and December 1, 1987. 125 of these Indians were King County residents. There are discrepencies between CMHIS data and Indian Health Board statistics, but the CMHIS data will be used in an effort to keep the analyses presented here as consistent as possible with the O'Sullivan et al. data. Further, the results are essentially the same whether the data is derived from the CMHIS or the Seattle Indian Health Board Mental Health Department.

If it is assumed that December is comparable to the other 12 months, a reasonsable assumption in 1987, an extrapolation of CMHIS data indicates about 136 Indian King County residents were served in 1987. If it is assumed that 100% of the King County Indian population sought some kind of health care service in 1986 and 1987, and that the Indian Health Board only provided 76.7% of these services, then 177 King County Indians sought mental health services in 1987. The income distribution of these Indians is probably similar to that reported in O'Sullivan et al. The substitution of these estimates into the O'Sullivan et al. analyses yeilds the results displayed in Table 6.

Insert Table 6 about here.

When the two confounding variables are considered, it becomes clear Indians are as underserved as other ethnic minority groups. Table 6 provides even more striking support for the hypothesis that all ethnic minority groups at all income levels receive fewer mental health services than Whites. Need is greater in minority communities, in part, because fewer services are available. The stress of poverty may also contribute to the observed need. In early work on social class and psychological distress, Hollingshead and Redlich (1958) concluded that poverty causes psychological problems. The data presented here indicates that those who suffer the most economic stress receive the fewest services.

This is a problem that can be solved, if the state is willing to commit adequate economic resources and delegate responsibility to existing minority mental health agencies.

Solutions

The socio-economic status of users of other components of the state mental health system is almost certainly similar to CMHC clients. Consequently, it is possible to calculate a population based estimate of the proportion of funds that should be spent on CMHC minority mental health clinics and on minority mental health in the state. The percentage of the ethnic population in each income catagory multiplied by the percentage of all CMHC clients that fall into that income catagory, summed over all income catagories, provides a very rough of the ethnic population served by the CMHC system. That figure is 26.1%. The governor of Washington (Gardner, 1986) proposed a mental health budget of $326,233,837 for the 1987-1989 bienium. The proposed 1987-1988 CMHC budget is $41,499,709. For 1988-1989, the governor hopes to provide CMHCs with $42,962,634. An income/population based distribution of funds would place over $85 million in ethnic minority mental health for the bienium. The formula above indicates nearly $11 million should be committed to the ethnic community mental health clinics in Washington State this year.

Though the state provides substantial funds to agencies that serve minority group members, a comparatively small proportion of funds is made available to agencies established and operated by the ethnic groups served. As noted above, mainstream mental health agencies may be unable to provide effective services to minority group members. A stronger committment to the minority agencies should improve service delivery significantly. This should include increased funding to existing programs, as well as the development of other minority mental health services. Culturally sensitive emergency services, inpatient and residential care are areas that desperately need to be addressed.

It is important to recognize the figures cited underestimate the actual percentage of funds that should be committed, if effective minority mental health services are to be delivered. Minority mental health agencies must bear all the costs of majority clinics in addition to a variety of unique expenses. Minority clinics must tailor psychotherapeutic services to the community served, include a therapeutic cultural component, and chart new therapeutic waters. Adaptations of the reverse sort are also requried. Minority agencies must meet the demands of majority accreditation agencies, auditors, and funding sources. These costs are just as high for agencies that serve the smaller minority groups, like the Seattle Indian Health Board.

A significant increase in funding to minority mental health agencies is necessary, but not sufficient, to ensure the delivery of adequate mental health services to ethnic minority clients. The state and county must also grant greater freedom to minority agencies. These agencies, with their unique expertise, are in the best position to develop and deliver the most effective services. When the state requires that minority agencies meet gaols that were developed for the majority, severe problems can arise. A goal may be set that is meaningless to some minority communities. For example, service to the "chronically mentally ill" is a worthy priority for the state. The concept however may not apply to several ethnic communities. There may not be a group of people who meet the intent of the term, yet there may be significant problems that demand intervention. Case management is an essential component of services to the chronically mentally ill. For the crucial psychological problems of some minority communities, individual psychotherapy, family services, alcohol treatment or some innovative treatment approach may be more cost efficient and treatment effective.

At present, the state and counties apply the same majority priorities to minority communities. Even those who beleive there is a universal set of psychological diagnoses contend that the frequency of conditions varies tremendously across cultures (eg, Westermeyer, 1987). It is curious that governments recognize that minority mental health treatment differs from majority approaches, but that these same governments do not recognize that minority needs, goals, priorities, and strategies may also differ from the majority. Perhaps ethnic minority mental health agencies could be charged with developing their own priorities, service goals, and community strategies.

The mental health problems of the minorities in Washington state are soluble. Governments need only fund adequately minority mental health agencies, established and supported by the communities these clinics serve, and allow these agencies the freedom necessary to solve the problems of their communities.

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Table 1

Washington State Child and Protective Service Referrals in 1986

	CPS cases	Estimated number of cases	Population (%)	Chi Square
Caucasian	61%	26,076	3,777,296 (88.9)	272.4**
Black	6%	2,565	105,544 (2.5)	3784.5**
Hispanic	3%	1,282	119,986 (2.8)	152.0**
Asian	1%	427	102,503 (2.4)	159.8**
Native American	4%	1,710	60,771 (1.4)	3461.6**
Other minority	1%	427	84,049 (2.0)	76.5**
South Asians		Not Reported	Not possible to analyze	
Unspecified	23%	9,832	Not included in analysis	
Total		42,747 referrals		

Note. CPS statistics from Patterson (1987). Only percentages and total number of referrals are reported. Number of cases for each ethnic group are estimated based on the two pieces of supplied data. Chi Square analyses use this estimate as the observed frequency and state census data (Bureau of Census, 1983) for the expected. The unspecified group was excluded from analysis. * $p < .05$; ** $p < .01$.

Table 2

A Sample of 1986 King County Involuntary Treatment Services

	(% Co. pop.)	Filed (% of filed)	Chi Square	Unfiled (% unfiled)	Chi Square
Asian	(4.6)	36 (3.6)	2.2	48 (3.0)	9.1**
Black	(4.4)	141 (14.0)	213.8**	171 (10.6)	140.8**
White	(86.3)	775 (76.9)	10.4**	983 (60.9)	120.7**
Native American	(1.0)	14 (1.4)	1.6	32 (2.0)	16.0**
Spanish Heritage	(2.1)	11 (1.1)	4.8*	25 (1.5)	2.4
Other	(1.6)	11 (1.1)	1.6	6 (0.4)	15.4**
Unknown		20 (2.0)		349 (21.6)	
South Asian		Not Reported		Not Reported	

Note. Filed indicates the client was involuntarily committed. Unfiled cases are investigated but not committed. Data is collected only four months of 1986: January, April, July and October. Data from Involuntary Treatment Services (1987). Chi Square analyses were performed using the above observed frequencies, and the expected frequencies reported in O'Sullivan et al. (1987).

Table 3

O'Sullivan et al. Data on Utilization Patterns in King County

	Clients in 20 CMHCs		County Population	
Group	n	%	n	%
White	10,267	74.5***	1,095,380	86.3
Black	1,356	9.8***	55,950	4.4
Native American	594	4.3***	12,437	1.0
Hispanic	262	1.9	26,631	2.1
Asian-American	742	5.4	58,712	4.6
Other	559	4.1	20,639	1.6
Total	13,780		1,269,749	

Note. CMHCs = Community Mental Health Centers.

Clients were compared with the county population.

While data are reported as percentages, chi-squares on frequencies were used for all comparisons.

*** $p < .001$.

Table 4

O'Sullivan et al. Income Data on Subjects

	White	Black	Native American	Hispanic	Asian
Monthly Income					
None	27.4	30.5	26.9	33.3	33.2
Below $100	4.1	3.4	2.6	.4	1.4
$100-249	6.5	7.4	3.8	3.1	3.6
$250-499	32.9	38:3	34.9	34.9	28.0
$500-749	9.4	9.9	10.4	13.6	13.6
$750-999	5.3	3.4	7.3	3.9	6.1
$1000 or more	14.4	7.0	14.2	10.9	14.2

Note. Numbers indicate percent of clients in each income catagory.

Table 5

Reanalysis of O'Sullivan et al. with clients matched for income

	CMHC Cases with Income < $6,000 (%)	Population Income < $5,000 (%)	Chi Square
White	7,279 (77.1)	29,450 (69.0)	89.6**
Black	1,079 (11.4)	5,661 (13.3)	24.9**
Native American	405 (4.3)	1,339 (3.3)	27.7**
Asian	491 (5.2)	4,347 (10.2)	231.3**
Hispanic	188 (2.0)	1,791 (4.2)	110.0**
South Asian	Not Reported		

	CMHC Cases with Income $6,000-$8,999 (%)	Population Income 5,000-$9,999 (%)	Chi Square
White	965 (74.4)	67,294 (79.7)	4.6*
Black	134 (10.3)	8,631 (10.2)	.3
Native American	62 (4.8)	1,930 (2.3)	34.1**
Asian	101 (7.8)	4,409 (5.2)	16.0**
Hispanic	36 (2.8)	2,167 (2.6)	.1
South Asian	Not Reported		

	CMHC Cases with Income > $9,000 (%)	Population Income > $10,000 (%)	Chi Square
White	2023 (81.5)	795,181 (89.2)	16.5**
Black	141 (5.7)	29,696 (3.3)	42.4**
Native American	128 (5.2)	7,664 (.9)	510.7**
Asian	151 (6.1)	45,258 (5.1)	4.5*
Hispanic	39 (1.6)	13,920 (1.6)	.03
South Asian	Not Reported		

Note. Population estimates based on Bureau of Census (1983). (See text for details). * p<.05; ** p<.01.

Table 6

Reanalysis of O'Sullivan et al. Indian data using statistics from the Seattle Indian Health Board and Washington CMHIS.

Estimated Number of Indian Clients at Each Income Level	Expected Number of Clients	Chi Square
<$6,000		
121	302	108.5**
$6,000 - $9,000		
18	29	4.2*
>$9,000		
38	22	11.6**

Note. * p<.05; ** p<.01.

Oversight Hearings—Comprehensive Community-Based Mental Health Initiative Statement

Submitted to the

Senate Select Committee on Indian Affairs

Presented by

Pamela J. Thurman
Human Services Director

July 7, 1988

Mr. Chairman and Committee Members, my name is Pamela Jumper Thurman. I am currently serving as Human Services Director for Indian Health Care Resource Center in Tulsa, Oklahoma. In this position, I supervise four programs:

1.) Community House - An outpatient chemical dependency treatment program.
2.) Indian Family Services - An Indian Child Welfare and Mental Health program.
3.) Fetal Alcohol Syndrome Project - A program that supports mothers with FAS/FAE children and performs community education and awareness prevention.
4.) Project TULSA - An adolescent primary prevention program focusing on overall wellness.

I will be completing my Ph.D. in Clinical Psychology this summer. I would like to thank you for the opportunity to appear before this committee to present testimony on Mental Health issues related to American Indians and Alaska Natives. I appreciate your interest in and consideration of this very important topic.

AMERICAN INDIANS AND MENTAL HEALTH TREATMENT ISSUES

I realize that most everyone is very aware of the history of American Indians - the removals, the broken treaties, the struggles that Indian people have faced for survival. Although these incidents are, for the most part, in the past, I believe that this rather chaotic and unstable history has created a residue of powerlessness and dependency that still affects many Indian people today. Townsley and Goldstein also attribute many of the psychological problems of Indian people to this helpless status. Many Indian people live in such a limited economic condition that even minor setbacks more easily become crises. When they do present for mental health treatment, the situation that brings them in is usually a major crisis - involvement with legal officials, (such as DUI, public drunk, possession of controlled substances, etc), an immediate need for drug or alcohol detoxification/treatment, or family issues (divorce, child abuse, sexual abuse, or financial crisis). It's important to note that presenting problems such as these certainly offer us valuable knowledge about the family systems and the workings of the community

It has been my experience that most of the presenting crisis situations have drug or alcohol involvement. In Oklahoma, current statistics are very high for American Indians in drug or alcohol treatment facilities but so are the recidivism rates. This suggests that drug and alcohol treatment is not enough. Alcoholism may be the presenting diagnosis, however, it's important to recognize that the underlying issues that must be dealt with to even begin reduce the recidivism rate. Treatment facilities may effectively treat the alcoholic, but when he or she returns to the reservation or community, they have to face the same unchanged family situation and community environment. I believe that it is essential to 1) include family members in the treatment process and 2) to develop a comprehensive community-based mental health program. Both become especially significant when considering the move toward deinstitutionalization. More and more I am seeing the chronically disadvantaged patient in need of mental health support services but lacking viable treatment options.

1) In urban Indian health facilities families present for social services and health needs that would also be appropriate mental health referrals. This pattern is probably evident in other Indian health facilities. For example, depression ranks high in many Indian patients and is most generally treated with medication only - no referral for mental health, likewise psychosomatic/psychophysiologic disorders (headaches, ulcers, hypochondriasis) are seen frequently but seldom referred for counseling. There are numerous children exhibiting Fetal Alcohol Symdrome and Fetal alcohol effects that aren't receiving appropriate mental health support services. Likewise, many mental health patients may have undetected medical problems, some of which could account for or compound their emotional or cognitive difficulties. Adjustment and anxiety disorders are often evident in Indians presenting for social services. These types of disorders are often the result of unstable family systems and the chemical use that is so prevalent among our people. Post traumatic stress disorder is seen too frequently in our children who have been physically abused or sexually molested by fathers, mothers, stepfathers, boyfriends, etc. These are some of the issues encountered on a daily basis. The problem lies in the lack of networking and referral. This results in a community denial of mental health problems - and a community in denial won't access the very services that could end the cycle of discomfort.

A coordination of professional services is obviously needed, and a multidisciplinary approach would be ideal. Such efforts would improve detection of mental health problems, improve services to patients, and allow the patients to gain access to some of the more specialized resources which they may be unaware of. In order to develop and maintain such coordination, staff training would be necessary to acquire skills in differential diagnosis, case consultation and multigenerational family therapy. Program policies would need to be examined and referral networks expanded. Multigenerational family therapy may be one of the most effective steps in bringing about positive community change.

2) There seems to be an expectation that all people respond identically to Mental Health interventions. This isn't true. Certainly, ethnic differences exist, and for American Indians, even tribal variances exist. I believe that the failure of mental health professionals to offer services appropriate to the specific sociocultural characteristics of the clientele is one of the barriers that seriously hinders the provision of services to American Indian people. One problem is the lack of Indian people with credentials to serve as psychiatrists and psychologists. Although mental health professionals may be available, few are American or Alaska natives yet it seems that Indian people seems to prefer to access services from other Indians with whom they can identify and who they believe, may be more sensitive to their needs. Therefore, it is imperative to encourage more Indians to enter the mental health professions.

However, when it isn't possible to have Indian people serving Indian people, it then becomes necessary for non-Indian mental health professionals to receive training which sensitizes them to the particular tribal culture(s) which they will serve. Many times, Indian people are grouped together under one stereotyped image when, in actuality, there are diverse characteristics that may reflect a tribes community - desert, mountains, rural, reservation, urban, etc.

3) Another major factor affecting mental health treatment of Indian people is the lack of access to and knowledge about programs available. Both urban and reservation or rural areas generally have various social services available, yet many Indians are either unaware that the programs

exist or are unable to comprehend what could be called the "bureaucratic run-around". In addition, many social service agencies believe, in error, that our people have "Indian money" available and they deny or delay services to the Indian client. Our clients frequently express that they have been treated in a superficial or even hostile manner. Sometimes language or semantic difficulties are a barrier. Though most of our clients are English speaking, they are not very verbal and service workers tend to dismiss them on this basis.

With a multidisciplinary approach, these barriers may be reduced. When a trained social worker or liason can accompany the clients to the service agency, they have support and at the same time, can learn a more effective method of interaction by observing the modeling behavior of the social worker.

4) Lastly, unemployment rates are high for many Indians and earning capacity is low. As a result, generally fall into poverty classifications. Those Indian people who live in poverty face severe strains on their lives and mental health worries are secondary to the basic survival needs: food, shelter, and clothing. Though depression and anxiety are very apparent, there is a lack of financial resources to seek and pay for mental health services. This situation is further complicated by the lack of knowledge about available resources and a lack of transportation to access services. Suicide and homocide rates are very high for some tribes. Grief also takes it's toll due to the many losses - family members, employment, etc. At this point, the depression itself becomes a debilitating barrier.

In closing, as a mental health professional, I believe that for the American Indian, community mental health programs may represent the only available help in coping with the problems of living in today's world. The emphasis on drug and alcohol treatment may give the mistaken impression that chemical dependency is the only mental health problem of American

Indians. And, it is of great concern, but the issues underlying the chemical use must be addressed. This is the only way I know of to reduce both alcoholism and the high recidivism rate while providing comprehensive and quality mental health services to American Indians. It is indeed a community problem and one that requires not only legislative consideration, but also a strong cooperative effort from several professional disciplines.

FACT SHEET

1988

Compiled by Indian Health Care Resource Center,
Tulsa, Oklahoma 74119

- * 16,507 American Indians live within the city limits of Tulsa, Oklahoma as projected from the 1980 Census (Indian Health Service). This is 70% of the total Tulsa County Indian population.

- * Tulsa Indians make up 5% of the total Tulsa population. Tulsa has the second largest American Indian population in the nation (1980 Census).

- * Indians primarily live in the Central, Western, and Northern sections of Tulsa, as indicated by Map 1 (Community Service Council 1980).

- * 32% of the Tulsa County Indians over 25 years of age have not completed high school. This compares to 28% for the general population (Bureau of Census 1983).

- * 17.3% of all Tulsa County residents living in poverty are American Indians. 50.2% of these are female headed households with children under six (6) years (Metropolitan Human Services Commission).

1980 Poverty Rates by Selected Characteristics for Tulsa County

	Tulsa County Percent in Poverty	Indian Percent in Poverty
All Persons	9.9	17.3
Families	7.1	13.8
Unrelated Individuals	21.3	32.3
Female Headed Families	24.3	36.0
with Children < 18	31.9	38.8
with Children < 6	45.8	50.2
Persons 65 Years and Older	13.1	23.3

- * The Tulsa urban Indian population ranks Group 1 for primary health care (Federal Register 1985) and Group 1 for dental care (Federal Register 1986). Group 1 represents those with the highest degree of professional manpower shortage to service their needs.

* Indians are five percent of the State's population, but have seven percent of the current state fetal deaths (Oklahoma Health Planning Commission, 1985).

* CY 1986 Leading Causes of Death by Rank and Race for Oklahoma

Cause of Death	Indian
Diseases of Heart	1
Malignant Neoplasms	2
Accidents of All Types	3
Cerebrovascular Diseases	4
Diabetes Mellitus	5
Nephritis, Nephrotic, & Nephrosis Syndrome	6
Pneumonia and Influenza	7
Suicide	8
Chronic Obstructive Pulmonary Disease	9
Arterlosclerosis	10

(Oklahoma Health Statistics, 1987)

* 14.6% of the clients served at Tulsa County's domestic violence program during fiscal year 1986 were American Indian (Oklahoma Department of Mental Health, 1986). Indians comprise 4.1% of the total County population.

* 9.4% of the clients served in fiscal year 1986 at Tulsa County stated funded alcohol and drug programs were American Indian (Oklahoma Department of Mental Health, 1986).

* Among Oklahoma Indian males, cirrhosis mortality as a primary cause of death is almost four (4) times higher than either the male Black or White population. For Indian females, about 5% of all deaths are due to cirrhosis, This compares to 1% for all Black and White females deaths (NIAAA, 1985).

* During calendar year 1986, 2,078 adult Indians in Tulsa County were arrested. Of this, 1,756 or 84% were alcohol and drug abuse violations (Oklahoma State Bureau of Investigation, 1987).

* 116 Indian juveniles were arrested in Tulsa County in 1986, 23.2% were alcohol and drug abuse violations (Oklahoma State Bureau of Investigation, 1987).

Indian Health Care Resource Center (IHCRC) began as an outreach/ referral program funded solely by Indian Health Service. In twelve (12) years, it has progressed to become a multiservice community center funded by federal, county, and private donations. IHCRC's progress is summarized below.

1976 - IHCRC forms and offers outreach and referral to Tulsa Indians.

1977 - Part time medical care, on-site laboratory, and dispensary are established. Cherokee Nation contracts with IHCRC for Women, Infants, and Children's (WIC) services. First and only tribal contract with an urban Indian organization in Oklahoma..

1980 - Indian Child Welfare Program provides family break up prevention services. Culturally relevant mental health counseling is available ten (10) hours/week.

1981 - Two (2) National Health Service Corps physicians and dentist join staff. Community Gardening Program revives traditional economic base and provides nutrition education.

1982 - Information collection and financial accountability are computerized. Quality Assurance and Suspected Child Abuse and Neglect (SCAN) Programs are implemented. Sliding fee scale for mental health services is established.

1983 - Transportation and child care services are expanded. Indian Child Welfare Program changes name to Indian Family Services and adds Adolescent component. IHCRC administers Jobs Bill contract for seven (7) counties adjacent to Tulsa County.

1984 - Volunteer Program is established. Indian Family Services adds another component - Early Childhood Development. Ongoing diabetes classes are introduced. Evening clinic on Thrusdays is established.

1985 - Non-smoking policy is established for entire clinic. Three fourths of the optometry examination equipment is procured.

Mental Health services are made available full time. IHCRC is approved as a Used Motor Vehicle Dealer for fund raising purposes. Services to adolescents are expanded by addition of a model cultural program and teen clinic night.

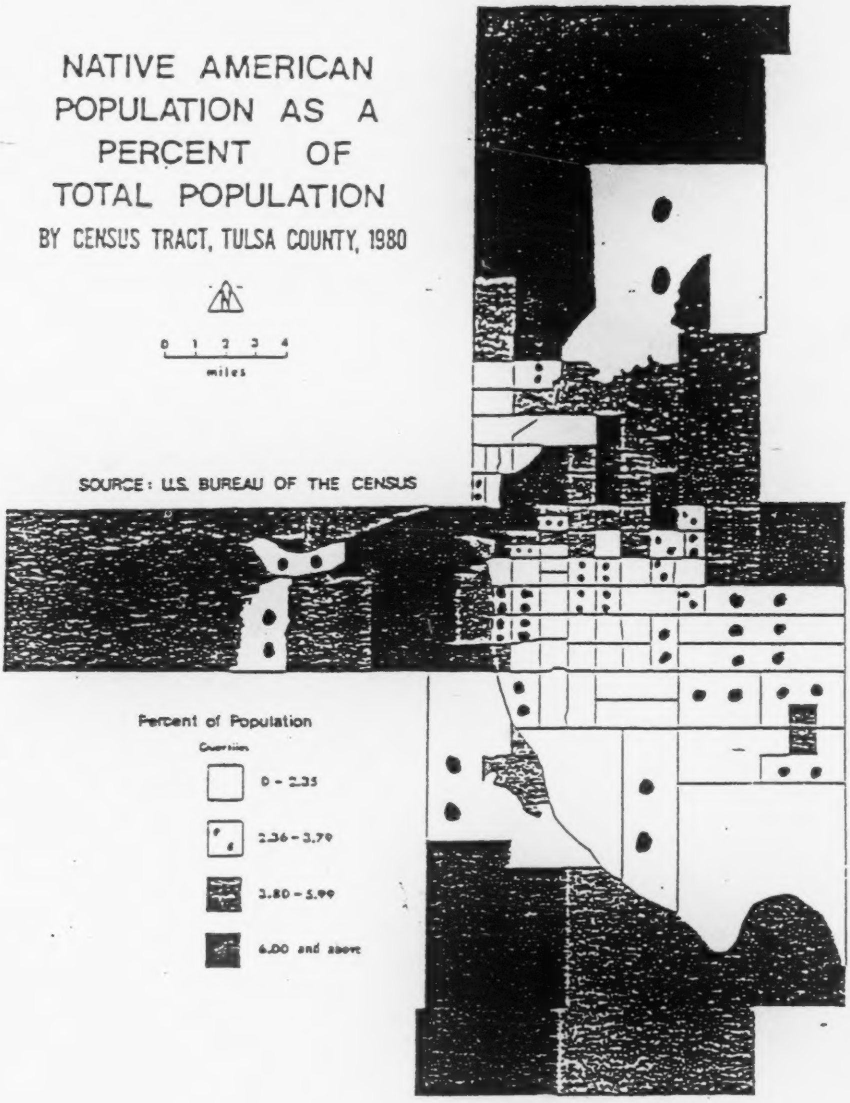
1986 - Medical Department expands by the addition of x-ray services. All optometry equipment is procured. A van for adolescent services is purchased. Indian Family Services adds Child Court Advocacy component. Community gardening program continues with no funding.

1987 - Indian Family Services expands again by adding a Child Court Advocate. Optometric examinations are available twelve (12) hours per month. IHCRC receives combined Federal Campaign Funds. A tympanometer and audiometer are donated by Southeast Sertoma.

MAP 1

NATIVE AMERICAN POPULATION AS A PERCENT OF TOTAL POPULATION

BY CENSUS TRACT, TULSA COUNTY, 1980


N
0 1 2 3 4
miles
Percent of Population
Quartiles
0 - 2.35
2.36 - 3.79
3.80 - 5.99
6.00 and above

SOURCE: U.S. BUREAU OF THE CENSUS

A PRODUCT OF
— METROPOLITAN HUMAN SERVICES COMMISSION —

PREPARED BY
COMMUNITY SERVICE COUNCIL OF GREATER TULSA
AUGUST [illegible]

OKLAHOMA DEPARTMENT OF MENTAL HEALTH
RESEARCH & EVALUATION SECTION

RATES UNDER TREATMENT FOR AMERICAN INDIAN SUBSTANCE ABUSE CLIENTS BY COUNTY OF RESIDENCE

COUNTY OF RESIDENCE	1980 CENSUS POPULATION TOTAL	MALE	FEMALE	FY 87 CLIENTS SERVED TOTAL	MALE	FEMALE	FY 87 RATE PER 1000 TOTAL	MALE	FEMA
ADAIR	6,209	3,062	3,147	11	9	2	1.77	2.94	0.6
ALFALFA	56	35	21	2	2	0	35.71	57.14	0.0
ATOKA	1,345	697	648	4	2	2	2.97	2.87	3.0
BEAVER	71	36	35	0	0	0	0.00	0.00	0.0
BECKHAM	202	88	114	9	4	5	44.55	45.45	43.8
BLAINE	961	447	514	38	24	14	39.54	53.69	27.2
BRYAN	2,289	1,084	1,205	6	3	3	2.62	2.77	2.4
CADDO	5,546	2,656	2,890	75	55	20	13.52	20.71	6.9
CANADIAN	1,679	875	804	49	30	19	29.18	34.29	23.6
CARTER	2,369	1,146	1,223	15	12	3	6.33	10.47	2.4
CHEROKEE	7,984	3,842	4,142	65	49	16	8.14	12.75	3.8
CHOCTAW	1,658	796	862	9	7	2	5.43	8.79	2.3
CIMARRON	32	19	13	2	2	0	62.50	105.26	0.0
CLEVELAND	4,066	2,066	2,000	67	39	28	16.48	18.88	14.0
COAL	719	344	375	2	2	0	2.78	5.81	0.0
COMANCHE	4,612	2,257	2,355	84	66	18	18.21	29.24	7.6
COTTON	490	231	259	2	2	0	4.08	8.66	0.0
CRAIG	1,834	896	938	17	10	7	9.27	11.16	7.4
CREEK	3,500	1,758	1,742	43	34	9	12.29	19.34	5.1
CUSTER	1,218	600	618	51	43	8	41.87	71.67	12.9
DELAWARE	4,960	2,518	2,442	11	8	3	2.22	3.18	1.2
DEWEY	302	147	155	10	5	5	33.11	34.01	32.2
ELLIS	35	15	20	0	0	0	0.00	0.00	0.0
GARFIELD	655	333	322	8	6	2	12.21	18.02	6.2
GARVIN	1,035	519	516	11	10	1	10.63	19.27	1.9
GRADY	1,000	468	532	26	15	11	26.00	32.05	20.6
GRANT	38	25	13	0	0	0	0.00	0.00	0.0
GREER	72	44	28	2	2	0	27.78	45.45	0.0
HARMON	30	14	16	0	0	0	0.00	0.00	0.0
HARPER	26	15	11	0	0	0	0.00	0.00	0.0

OKLAHOMA DEPARTMENT OF MENTAL HEALTH
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RATES UNDER TREATMENT FOR AMERICAN INDIAN SUBSTANCE ABUSE CLIENTS BY COUNTY OF RESIDENCE

COUNTY OF RESIDENCE	1980 CENSUS POPULATION			FY 87 CLIENTS SERVED			FY 87 RATE PER 1000		
	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE
HASKELL	990	485	505	2	1	1	2.02	2.06	1.9
HUGHES	1,944	937	1,007	11	9	2	5.66	9.61	1.9
JACKSON	286	141	145	3	3	0	10.49	21.28	0.0
JEFFERSON	211	97	114	3	1	2	14.22	10.31	17.5
JOHNSTON	1,181	575	606	9	6	3	7.62	10.43	4.9
KAY	2,662	1,370	1,292	99	77	22	37.19	56.20	17.0
KINGFISHER	308	138	170	2	1	1	6.49	7.25	5.88
KIOWA	560	281	279	10	8	2	17.86	28.47	7.17
LATIMER	1,385	676	709	3	1	2	2.17	1.48	2.82
LeFLORE	3,057	1,482	1,575	8	4	4	2.62	2.70	2.54
LINCOLN	906	445	461	10	8	2	11.04	17.98	4.34
LOGAN	332	150	182	3	1	2	9.04	6.67	10.99
LOVE	362	178	184	0	0	0	0.00	0.00	0.00
McCLAIN	693	334	359	6	4	2	8.66	11.98	5.57
McCURTAIN	3,637	1,739	1,898	35	28	7	9.62	16.10	3.69
McINTOSH	1,891	938	953	0	0	0	0.00	0.00	0.00
MAJOR	116	50	66	6	6	0	51.72	120.00	0.00
MARSHALL	745	352	393	17	13	4	22.82	36.93	10.18
MAYES	4,363	2,178	2,185	14	9	5	3.21	4.13	2.29
MURRAY	801	382	419	20	14	6	24.97	36.65	14.32
MUSKOGEE	5,549	2,634	2,915	73	51	22	13.16	19.36	7.55
NOBLE	703	366	337	59	49	10	83.93	133.88	29.67
NOWATA	1,106	553	553	1	0	1	0.90	0.00	1.81
OKFUSKEE	1,620	807	813	15	13	2	9.26	16.11	2.46
OKLAHOMA	14,247	6,910	7,337	328	219	109	23.02	31.69	14.86
OKMULGEE	3,470	1,704	1,766	15	9	6	4.32	5.28	3.40
OSAGE	4,749	2,343	2,406	100	65	35	21.06	27.74	14.55
OTTAWA	4,192	2,026	2,166	28	25	3	6.68	12.34	1.39
PAWNEE	996	493	503	31	19	12	31.12	38.54	23.86
PAYNE	1,587	818	769	60	47	13	37.81	57.46	16.91

OKLAHOMA DEPARTMENT OF MENTAL HEALTH
RESEARCH & EVALUATION SECTION

RATES UNDER TREATMENT FOR AMERICAN INDIAN SUBSTANCE ABUSE CLIENTS BY COUNTY OF RESIDENCE

COUNTY OF RESIDENCE	1980 CENSUS POPULATION			FY 87 CLIENTS SERVED			FY 87 RATE PER 1000		
	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMA
PITTSBURG	3,120	1,528	1,592	42	22	20	13.46	14.40	12.
PONTOTOC	2,442	1,182	1,260	102	89	13	41.77	75.30	10.
POTTAWATOMIE	4,010	1,963	2,047	104	77	27	25.94	39.23	13.1
PUSHMATAHA	1,222	604	618	6	6	0	4.91	9.93	0.
ROGER MILLS	319	153	166	11	10	1	34.48	65.36	6.
ROGERS	4,082	1,959	2,123	29	18	11	7.10	9.19	5.1
SEMINOLE	3,718	1,825	1,893	24	19	5	6.46	10.41	2.
SEQUOYAH	4,461	2,202	2,259	14	10	4	3.14	4.54	1.7
STEPHENS	918	447	471	5	5	0	5.45	11.19	0.0
TEXAS	129	67	62	7	7	0	54.26	104.48	0.0
TILLMAN	317	165	152	1	1	0	3.15	6.06	0.0
TULSA	19,037	9,174	9,863	397	282	115	20.85	30.74	11.6
WAGONER	2,732	1,355	1,377	13	11	2	4.76	8.12	1.4
WASHINGTON	2,716	1,314	1,402	78	53	25	28.72	40.33	17.
WASHITA	158	75	83	2	2	0	12.66	26.67	0.0
WOODS	61	35	26	3	3	0	49.18	85.71	0.0
WOODWARD	208	110	98	19	18	1	91.35	163.64	10.2
TOTAL STATE	169,296	82,773	86,523	1,828	1,324	504	15.99	23.75	8.

OKLAHOMA DEPARTMENT OF MENTAL HEALTH
RESEARCH AND EVALUATION SECTION
Distribution of Length of Stay
by Patient Characteristic and by Admission Type
Among Discharges with Substance Abuse Problems
Date of Report: 5 / 88

Year: FY 87

Variables		First Admissions: No. of Admissions	%	LOS		Readmissions: No. of Readmissions	%	LOS
Total		10392	100%	98.07 Days		2797	100%	65.94 Days
Sex								
Male		7568	73%	92.73		2279	81%	59.94
Female		2734	26%	116.50		518	19%	92.31
F Value	51.05				26.63			
p	0.00				0.00			
Race								
Amer Indian		1105	11%	105.23		432	15%	60.18
Black		987	9%	82.91		235	8%	66.40
White		8095	78%	99.87		2095	75%	66.94
Other		205	2%	107.71		35	1%	87.51
F Value	4.77				0.66			
p	0.00				NS			
Age Groups								
LT 18		810	8%	139.71		87	3%	124.94
19-25		2614	25%	105.74		416	15%	92.26
26-34		3569	34%	89.04		830	30%	70.00
35-44		1902	18%	97.86		694	25%	66.40
45-54		975	9%	84.94		433	15%	40.60
55-64		401	4%	86.49		216	8%	37.76
65+		121	1%	122.47		121	4%	42.98
F Value	15.65				11.37			
p	0.00				0.00			
Primary Problem								
Alcohol		6977	67%	103.25		2,157	77%	60.84
Drug		3249	31%	88.79		608	22%	81.26
Other Substance		166	2%	119.26		32	1%	118.38
F Value	11.91				0.60			
p	0.00				0.00			
Secondary Problem								
Alcohol		6977	67%	103.25		2,157	77%	60.84
Drug		3249	31%	88.79		608	22%	81.26
Other Substance		166	2%	119.26		32	1%	118.38
F Value	-11.91				0.60			
p	0.00				0.00			
Dual Prob Type								
Primarily Alco		5033	48%	111.79		1,766	63%	61.15
Alco/Drugs		1944	19%	81.13		391	14%	59.63
Primarily Drug		3249	31%	88.79		608	22%	81.26
Other		166	2%	119.26		32	1%	118.38
F Value	27.74				5.75			
p	0.00				0.00			

OKLAHOMA DEPARTMENT OF MENTAL HEALTH
RESEARCH AND EVALUATION SECTION
Distribution of Length of Stay
by Patient Characteristics and by Admission Type
Among Discharges with Substance Abuse Problems
Date of Report: 5 / 88

Description of the Data Base

The data base consists of FY 87 discharges who presented substance abuse-related primary problems.

Thirteen thousand one hundred eighty-nine (13,189) substance abuse clients were discharged from Oklahoma Department of Mental Health (ODMH) funded agencies during FY 87. Nearly 80% of these discharges had been first admissions. The discharges who had been first admissions stayed an average of about 99 days during their episode of care, while the discharges who had been readmissions only stayed about 67 days.

Nearly three-quarters of discharges who had been first admissions were male. This cohort of discharges was nearly 80% white; while nearly 60% were between the ages of 19 and 34 years old. Almost 70% of the substance-abuse related discharges presenting alcohol problems.

The discharges who had been readmitted consisted of a greater proportion of males (almost 80%) than did the first admission discharges (with only 73%). In terms of race, this cohort of discharged readmissions also experienced a 30% higher proportion of American Indian readmissions, as American Indians made up 15% of the discharged readmissions. Also, clients experiencing alcohol-related presenting problems dominated FY 87 discharges who had been readmissions.

Hypothesis Tested

Variance in Length of Stay (LOS) can not be accounted for by the differential patient characteristics examined. The characteristics examined include sex, race, age group, primary presenting problem, secondary presenting problem and problem type.

Analytical Approach

Analysis of Variance (ANOVA) was utilized. The purpose of ANOVA is to show the proportion of variance in LOS which can be accounted for by each variable reviewed. In each of the one-way analysies of variance, the F test was performed. The F is a test statistic showing the significance of sample means. The ratio divides variation due to each independent variable (such as sex, race, problem, etc.) by variation due to chance. If variation due to the independent variable is of no effect, or zero then the F value is 1. Thus, if the independent variable does not effect the LOS, one would expect the F value to be 1 or less. If, on the other hand, the independent variable does effect the dependent variable (LOS), one would expect the F value to be greater than 1.

The best explanatory variables will be determined by the largest F values significant at the 0.05 level. Significant finding for this research will be determined by p values less than or equal of 0.05. This selected level of significance indicates that there is, at least, a 95 out of 100 chance that the hypothesis is incorrect.

Although the ANOVA model assumes independent random sampling, as well as an interval level dependent variable (such as LOS) and and a nominal level predictor variables, the study group consists of 100% of the FY 87 discharges who were admitted for substance primary presenting problems.

Findings

According to the data, sex is the best predictor of LOS among discharges experiencing their first admission (with an F value of 51.05 at the 0.00 significance level). The next best predictor of LOS among these discharges is problem type (with an F value of 27.74); then age group (with an F value of 15.65).

Female discharges who had been first admissions and presented substance abuse-related problems stayed a mean of 117 days, compared to 93 days for male discharges.

Discharges who had been first admissions and presented abuse of other substances (such as inhalants) stayed a mean of 119 days; these presenting primarily alcohol abuse stayed for 112 days; those presenting primarily drug abuse stayed for 89 days; and those who presented both alcohol and drug problems stayed for 81 days.

The youngest and the oldest age group cohorts experienced the longest LOS, with 140 and 122 days, respectively. Those discharges who 19 to 25 years old stayed a mean of 106 days; while the remaining age group cohorts experienced LOS ranging from about 85 to 100 days.

Among the FY 87 discharges who had been readmitted, sex, age group and presenting problem were the three best predictors of LOS, with F values of 26.63, 11.37 and 8.60, respectively.

Again, among the readmitted, the female discharges had stayed for an average of 92 days, compared to a mean of about 60 days for male discharges. The youngest age group cohort experienced the longest LOS with 125 days. The oldest age group, however, experienced one of the two shorter LOS episodes with 43 days.

Those experiencing problems with other substances (such as inhalants) stayed over twice as long (with 118 days) as did those who were experiencing alcohol problems.

It is interesting to note that, although race was a significant predictor of LOS among those discharges experiencing their first admissions (F value is 4.77), race did not significantly predict LOS among those discharges who had been readmitted.

Yukon-Kuskokwim Health Corporation

"Fostering Native Self-Determination in Primary Care, Prevention and Health Promotion"

Written Testimony to be Included

in the

Oversight Hearing on the Community Mental Health Initiative

of the

Senate Select Committee on Indian Affairs

by

Barbara Newman, M.D., M.P.H., Medical Director

Yukon Kuskokwim Health Corporation

July 7, 1988

Mr. Chairman and members of the Senate Select Committee, the Yukon Kuskokwim Health Corporation appreciates the opportunity to address you on the mental health needs of Native Alaskans.

The Yukon Kuskokwim Health Corporation (YKHC) is a private, non-profit health corporation that delivers primary care, educational, preventive and planning services to the people of the Yukon Kuskokwim Delta Region of Alaska. Funding for the Corporation is primarily provided through the Indian Health Service (Alaska Area Native Health Service) and the State of Alaska.

Organized in 1969 as part of the Office of Economic Opportunity's effort to develop consumer controlled health organizations, YKHC presently operates as a federally designated contractor under PL 93-638, the Indian Self Determination Act. The voting members of the Board of Directors are Alaska Natives from the Yukon Kuskokwim Delta Region.

The Corporation has an annual budget of approximately 8 million dollars and operates 18 programs.

The Yukon-Kuskokwim (Y-K) Delta, roughly 75,000 square miles in Southwestern Alaska, is home to approximately 20,000 inhabitants, 16,000 of whom are Alaska Natives (predominantly Yupik Eskimos, with a small number of Athabascan Indians). The population center is in Bethel (4,500 people) with the remaining population dispersed in 48 villages ranging in size from 30 - 750 people. The geography and climatic environment restrict travel and communication. Use of small planes, boats in the summer and snow machines in the winter are the only means of travel within the region. Within the last five years, each village has been linked to a communication system to allow immediate linkage with other population centers through a telephone. Many of the villages have only one telephone.

Most Alaska Natives in the Delta derive all or a substantial part of their food from subsistence activities - hunting, fishing, trapping. They are Catholic, Moravian or Russian Orthodox - but retain many of the beliefs of their pre-western contact spiritualism. They attend schools where the courses are taught in English, and live under US laws. There is no "Indian Country" in the Y-K Delta. Healthcare, including mental health services, is financed directly by the Indian Health Service, indirectly by agencies with whom the IHS has contracts, and to a lesser extent by the State of Alaska.

Devastating mental health problems plague the Native population of this area. Schematically, these problems can be divided into 3 areas: depression, substance abuse, and chronic mental illness. In reality, the three areas are inextricably intertwined, and intertwine also with the economic and political life of the region.

Depression can be simply defined as the loss of the ability to enjoy life, to grow, to interact. It is a subtle yet all-pervasive mental illness, often unrecognized until in its most devastating stages. In the YK Delta area, we see it most often in the form of suicide threats, attempts and completions. To say that suicide is epidemic here would be an understatement. The suicide rate (completions only, which are the tip of the iceberg) for Alaska Natives is 2 times that of Alaskans as a whole, and 4 times that of the US population. For Alaska Native males between the ages of 20 and 24, it is 13 times that of Alaska, and 25 times that of the US.

During the week of June 27, 1988, a physician at the IHS Hospital in Bethel, reported that she had participated in the attempted resuscitation of 2 drowning victims - a mother who jumped in the Kuskokwim River to commit suicide, and her son attempting to save her (both died); a young husband threatening suicide after his schizophrenic wife was admitted to the Alaska Psychiatric Institute in Anchorage; and a young woman who took an overdose of Tylenol after being beaten by her husband.

Alcohol has been the down fall of the Alaska Native - an escape from the depression resulting from loss of culture; loss of loved ones in the unending litany of suicides, injuries from operating boats, snowmachines or 3-wheelers while intoxicated, and domestic violence; and loss of self-esteem.

Although alcohol is the most commonly abused substance, marijuana and cocaine are increasingly available, and certain villages have a large number of young children involved in gas-sniffing. Alcohol is involved in virtually every one of the numerous incidents of spouse abuse, Elder abuse, rape, and child sexual abuse - all of which abound in the Delta.

The Delta has its share of severely, chronically mentally ill people, too. But adequate treatment of schizophrenics, manic-depressives, and major depressives is complicated by the lack of psychiatric hospital services anywhere but Anchorage, few psychiatrists in rural communities, and logistical problems in medication monitoring of patients in widely scattered villags.

Underscoring all this, is a formidable dependence that has been fostered in Alaska Natives; a loss of faith in their ability to tackle these problems on their own. It is clear that from the time of the first Russian trappers, to the American missionaries, to the US Dept. of Fish and Game, to the Indian Health Service, the Alaska Natives have become a colonized people. This tremendous loss of a sense of control over their destiny has directly contributed to the diminished mental health of Alaska Natives.

Though still inadequate, the development of mental health services in Alaska have been steadily increasing over the years. However, the mental health problems are increasing at a far faster rate. In order to curb this escalating mental health problem, approaches must be developed which foster Native control over and involvement in their own destiny, thereby decreasing dependency.

Such re-assertion of control can be facilitated. A model for this service delivery exists in YKHC's Community Health Aide Program, in which Native villagers are trained as Physician Assistants, and staff clinics in each village. In consultation with the physicians at the Bethel PHS Hospital, they service most of the primary health care needs of the villagers.

A similar structure could be operated to address mental health problems. A pilot mental health program of this nature in one coastal village (Hooper Bay) is now underway. State funds pay the salaries of a Mental Health worker and two Elder consultants. The young Mental Health worker is trained and supervised by the clinicians of YKHC's Mental Health Center in Bethel. Through increased Native involvement and participation, villagers will gain a sense of empowerment to deal with and prevent suicides, to counsel the depressed, monitor medications of the chronically mentally ill, etc.

At times the mental health problems, substance abuse and domestic violence appear to be overwhelming. Yet, YKHC is optimistic that well-planned interventions will begin to make an impact . For over one and one-half years, YKHC has been recruiting for a psychiatrist to serve the Y-K Delta population. Attracting psychiatrists to Southwestern Alaska is an extremely trying experience. Fortunately, our efforts have reaped a harvest and two psychiatrists will arrive in August for a one-year stint. With the addition of these health professionals, YKHC can re-evaluate our programs, offer more psychiatric services to clients, and provide more psychiatric support to our clinicians and paraprofessionals.

In addition, YKHC has initiated the formation of a Mental Health Task Force comprised of local providers and consumers to address the mental health problems of the YK Delta Region. As the Task Force formulates additional approaches to alleviating these problems, we will share them with the Select Committee.

YKHC also wished to express our appreciation to Senator Inouye in advance for his scheduled trip to Alaska, which includes Bethel, over the Labor Day weekend to learn first hand about the tremendous challenges that we face in health services delivery in bush Alaska.

NANA REGIONAL CORPORATION, INC.
POST OFFICE BOX 49 / KOTZEBUE, ALASKA 99752 / TELEPHONE (907) 442-3301

July 6, 1988

United States Senate
Select Committee on Indian Affairs
Daniel K. Inouye, Hawaii Chairman
Daniel J. Evans, Washington - Vice Chairman
Washington, D.C. 20510-8450

Dear Mr. Inouye and Mr. Evans:

Thank you for this opportunity to testify. On behalf of the native people of the NANA Region, which is predominantly Inupiaq, I would like to provide you with a perception from the Alaska Natives of the NANA Region on the issue of Mental Health. I purposely choose the word "issue", since it is being dealt with as such. I have included a copy of a series of articles titled "A people in Peril", by the Anchorage Daily News, which graphically portrays the extent of a component of mental health, which is alcohol and drug abuse. Quite clearly, this is a problem of monumental porportions.

On the issue of Mental Health, it is easier of us to understand if we think of it as a "Layered" problem; on the surface, we have the well being of the native people; underneath is the alcohol and drug abuse, and beneath that is a myriad of other problems such as sex abuse, neglect, family violence, and others.

The alcohol abuse and the eventual result interact and perpetuate the other, if allowed to continue. This structure resembles the full circle of what the whole of this situation is: It is Mental Health. The significance of the effects of a problem of such magnitude is that the people affected do not have control of their lives and lifeways, and that is the basic core of the problem.

Page 2
Mr. Inouye and Mr. Evans
July 6, 1988

Inupiaq people, as a distinct culture, has survived on the Western perception of a harsh and cruel climate, and of late in the past 100 years in our region has had to adapt itself into the 20th century. The effects of cultural upheaval is very recent, and the resulting problems are somewhat more understandable, as it is within a few lifetimes that cultural devastation that the native people in our region have experienced has led to an awareness that the native people themselves, from within themselves, can preserve and perpetuate their own identity on a positive note. In short, they must have some control as well as a part of any program meant for them.

In closing, I would like to ask you to ponder this statement: The solution to Native American problems must come from within the Native Americans themselves. With your assistance, this is quite possible.

Thank you.

Pete Schaeffer
Vice President
NANA Regional Corporation

Enclosure: Anchorage Daily News Publication
A Special Print - A People In Peril
Federally Expressed July 6, 1988

Alaska State Senate

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Senate Finance Committee
State Affairs Committee
Vice-Chair, Rules Committee
Chair, Administrative Regulation Review

William L. Hensley

July 5, 1988

Senator Daniel Inouye, Chairman
United States Senate Committee
on Indian Affairs
838 Hart Office Building
Washington, D. C. 20510

Re: Committee hearings on Community Mental Health

Dear Senator Inouye,

I respectfully request that the attached March, 1988 report by the State of Alaska Senate Special Committee on Suicide Prevention be entered into the written record of your committee's hearings on community mental health.

This report provides a description of the alarming statistics of death by suicide in Alaska, particularly among young, rural Native peoples. It provides a summary of concerns and opinions expressed by a broad cross section of citizens on the nature of the problem and how to confront it. Finally, it sets out recommendations for governmental actions which hold near term promise for people at risk.

I applaud the attention that the Committee on Indian Affairs is giving to community mental health problems. The conditions and factors that contribute to the high rates of suicide in Alaska are not well understood. What is clearly apparent is that present efforts at improving community mental health are failing. In my opinion, the situation requires innovation in finding more appropriate ways and methods of treating people at risk.

I hope the committee finds our report useful. Given the information it contains, it may be that the committee will want to hold a hearing in Alaska. In that event, please know that the Special Committee on Suicide Prevention will assist you in any way it can.

Sincerely,

Willie Hensley

William L. Hensley, Chairman
Senate Special Committee on
Suicide Prevention

INTERIM REPORT
OF
SENATE SPECIAL COMMITTEE ON SUICIDE PREVENTION

BY

Senator William L. Hensley, Chairman
Senator Johne Binkley
Senator Richard Eliason
Senator Pat Rodey
Senator Bettye Fahrenkamp

STATE OF ALASKA

MARCH 1988

ACKNOWLEDGEMENT

The committee gratefully acknowledges the valuable council and assistance of Susan Soule from the Department of Health and Social Services, Edna MacLean and Helen Mehrkens from the Department of Education, John Pugh and Barbara Minton from the University of Alaska Southeast, and Steve McPhetres from the Alaska Council of School Administrators.

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INTRODUCTION

It is the strangeness that causes the bewilderment and incomprehension of death by suicide. Why should a person consciously choose this solution and its finality over the condition of living? How can a person's natural instinct to survive be so eroded or overwhelmed?

It is the dramatically increasing frequency of suicide and suicide attempts that causes the alarm. Why are Alaska's suicide rates so much higher than national averages? Why are they so high among youth? Do these increasing occurrences indicate fundamental societal flaws or forces we do not understand or are not even aware of?

With these kinds of feelings and questions I attempted to respond to the many pleas for legislative help during the last session on the problem of suicide. Furthermore, I found that my Senate colleagues similarly faced a growing concern about the occurrence of suicide deaths in all parts of the state and were equally perplexed. What should be done? The uncertainties of the nature and causes of the problem were matched by uncertainties about programs available to help address the problem.

I introduced Senate Resolution 19, Establishing a Senate Special Committee on Suicide Prevention, to bring some focus to the problem and find some answers. Its quick passage testified to the Senate's regard for the importance of the issue. Besides myself, Senators Binkley, Eliason and Rodey and the late Senator Bennett were appointed to provide the breadth of experience and geographical representation that the issue required. The committee was charged with investigating the problem of suicide in the state, especially among Native peoples and Alaska's youth. Equally important, the committee was also charged to search for, review, and recommend programs that had shown success in the prevention and treatment of suicide.

From the beginning we recognized that the problem had many diverse elements and aspects. Community, economy, family, school, mental health, alcohol and drug abuse, cultural factors may all play a role in an individual situation. We also recognized that any programmatic attempt to address the needs of people at risk would have to necessarily involve almost all state and local structures we have established to protect the health, education, and social well being of Alaska's citizens. Furthermore, we recognized that the nature of the problem in a rural setting may not be identical to that in the urban setting. Efforts to successfully prevent or treat suicide attempts then would be significantly dependent on their suitability to a community or area.

During the period between legislative sessions the committee sought to:

1. Review all published research, studies, and reports pertinent to Alaska's suicide problem.

2. Solicit the knowledge, experience, and opinions of Alaska's professionals in social work, health care, public protection, and education who confront the problem of suicide.

3. Solicit the knowledge and opinions of the Alaskan general public who through direct experience and concern offer insight into what can or should be done about the problem of suicide.

These last two goals were accomplished in large part through a series of public hearings held in Sitka, Anchorage, Fairbanks, Bethel and Kiana.

This report is a consolidation of the committee's effort to date. It includes contributions from persons of many occupations, often arising from personal experience with suicide. Students, parents, Elders, agency people, and educators testified to the seriousness of the problem and the desire and critical need for government action.

The large response to our effort affirmed the necessity and importance with which Alaskans viewed the work of the committee. It also underscored the recognition that ultimately any solution would require not only action by the State, but the understanding, cooperation, and efforts of all segments in a community or region.

William L. Hensley, Chairman
Senate Special Committee on
Suicide Prevention

REVIEW OF CURRENT KNOWLEDGE OF SUICIDE IN ALASKA

Suicide has been recognized as a major health problem in Alaska for at least a decade and a half. As early as 1971 Kraus presented a paper at the Second International Symposium on Circumpolar Health which reviewed suicides among all Alaska natives between 1950 and 1970. He reported a stable incidence rate between 1950 and 1964 but described a sudden doubling of the rate in 1965. This higher rate continued through the end of the study period in 1970. Kraus reported that the increase was accounted for almost entirely by suicides in the 10 to 30 year age group with the highest risk among 15 to 25 year olds. In 1978 Kraus, in collaboration with Buffler, published a second report which further documented the seriousness of suicide in Alaska. The report noted that during the period of 1970 - 1974 the Alaska Native rate of suicide was approximately 3.5 times greater than the Alaska non-native and the general U.S. population rates and almost two times the rate for all American Indians.

In late 1978 Blackwood issued a report for the Indian Health Service on suicide. He states:

> "In the 1950's, suicide, deaths averaging 5 per year, were a relatively insignificant problem for Alaska Natives. The suicide death rate fell way below the ten leading causes of death at the time. Since then however, suicide has risen to become the second leading cause of death for Alaskan Natives."

Blackwood not only confirmed Kraus and Buffler's data on Alaska Native suicides during the early 1970's but also indicated that reported injuries (morbidity) resulting from suicide attempts among Alaska Natives showed that for every suicide death there were from 10 to 20 serious suicide attempts. This suggests an even more serious problem than indicated by the high suicide rates alone.

In 1984 the Alaska State Legislature, at the urging of the Native Health Corporations, appropriated funds for the Alaska Native Health Board to conduct the Rural Health Issues Study and Statewide Suicide Evaluation Project. In November of 1985 the report was issued and it found that "Suicide attempts and completions occur more frequently among the Alaska Native Population than among non-Native Alaskans." The report further documented the changing trend towards more youthful suicides in the Alaska Native population. The highest at risk group in the 1980's has been the 15 to 24 year old Alaska Native male. This latter statistic was confirmed through 110 unvalidated community responses to the ANHB Suicide Survey. The survey responses also demonstrated a high suicide attempt rate among Native females in the same age group.

The most comprehensive statewide study of suicides in Alaska was completed by Forbes and Van Der Hyde in 1986. They found that during the years of 1978 - 1984 Alaska's suicide rate was among the four highest in the United States in every year except 1979. They noted that the rate of suicides among 15 - 24 year old Alaska Native males was more than six times the natural rate for white males in the same age group.

In late 1986 Hlady and Middaugh issued their epidemiologic report on suicides in Alaska in 1983 - 1984. They found the annual age-adjusted suicide rate of 21 per 100,000 for Alaska as a whole to be almost double the national average. The rate for Alaska Natives of 43 per 100,000 was twice the overall Alaskan rate. The report indicated that the highest rate of suicide was among Alaska Native males, aged 20 - 24 years, 257 per 100,000. This rate is 13 times the Alaskan average.

Hlady and Middaugh's report not only documented the seriousness of suicide in Alaska but also delineated significant problems with the system used by Bureau of Vital Statistics to gather and record data on suicides in Alaska. They indicated that most of the studies prior to 1986 relied heavily on data from the Bureau which was inaccurate due to incidences of underreporting of data (a suicide is officially reported as something else), misrecording of data (a suicide is reported but recorded as an accidental death), and underrecording (a suicide is officially reported on a death certificate but is not recorded in the Bureau's data system). These discrepancies are highlighted in Marshall and Soule's 1986 report on suicide deaths in the Yukon-Kuskokwim Delta during 1979 - 1984. Of the 32 suicides identified, only 7 appeared in the Bureau of Vital Statistics data system. Seventeen of the 32 suicides were misrecorded and underrecorded. Underreporting added another eight to the total.

During this same time period Forbes and Van Der Hyde evaluated the Bureau's computerized data system. They found that the required death certificates were being filed in a timely manner, but the legal determination of suicide was made weeks or months later at the autopsy or inquest and this new information often was not entered into the data system. Their review of death certificates for 1978 - 1984 indicated that 38% of officially reported suicides did not appear in the data system. Hlady and Middaugh's report made a number of recommendations for improvements to the Bureau's data collection recording system. These will be considered in the recommendations section.

The studies cited in the preceding pages focus on the epidemiology of suicide in Alaska. Such studies tell us who, in terms of sex, age, ethnicity and location, is committing and attempting suicide, in what numbers and how that information compares to information from other places. Detailed epidemiological studies can describe many characteristics of a given group of suicides and can note patterns, as Marshall and Soule's 1986 study of suicide in the Yukon-Kuskokwim delta noted that of 28 suicides by Alaska Native males, 75% were between the ages of 15 and 34; over 89% had never been married; over 78% died by gunshot; over 71% of those who committed suicide were intoxicated at the time of their deaths. Such studies can provide a detailed picture of the "typical" suicide, but cannot answer the critical question, "why?"

Etiological studies focus on the causes of suicide. They seek to answer the question "why." There are few etiological studies of suicide in Alaska. Kost-Grant (1983) reports on psychiatric consultations concerning 34 Alaska Natives who survived a self-inflicted gunshot wound and notes that most cited interpersonal conflicts, an argument with a family member, rejection by a boy or girlfriend, as a partial cause of the suicidal action.

Most etiological speculation has been based less on hard data and more on the experiences, conversations, and insights of their author and on more formal work completed outside Alaska. In 1985 the Alaska Native Health Board issued a study based in large part on "extensive anecdotal evidence from every city and village in the state." Information was collected from public meetings, a written questionnaire and face to face and telephone interviews. While primarily epidemiological in approach, the study does suggest a link between suicidal behavior and community stress, citing specifically the stress caused by rapid social change.

Most of the literature that addresses the possible reasons for the terribly high suicide rate among young Alaska Native males suggest that both the personal factors, as cited by Kost-Grant, and the sociocultural factors, as described by the Alaska Native Health Board are contributors to the problem. There is not one cause of suicide only the last in a series of causes.

The public testimony received by this committee indicates that many Alaskans, professional health care providers, teachers, students, villagers urbanites share the view that personal, social and cultural pressures contribute to the feelings of helplessness and despair that lead to suicide.

Epidemiological studies have informed Alaskans about the size of the problem. The overall rate of suicide in Alaska in recent years is almost twice the national rate. The rate of suicide among Alaska Natives is double the all Alaskan rate. The rate of suicide among Alaska Native males between 15 and 24 is six times the national rate for that age group.

Epidemiological studies have told us that the suicides are not distributed evenly across the state, but rather that some regions and some villages within regions have much higher rates than others.

Epidemiological studies have also told us that from two thirds to three quarters of Alaska Native suicides are alcohol-related and that most involve the use of a firearm.

Works that speculate on the causes of suicide point to rapid culture change, dysfunctional families, the personal and interpersonal havoc caused by alcohol abuse, the accumulation of overwhelming grief created by the too often violent deaths of too many family members and friends.

But for all the studies, all the speculation and all the concern, we still cannot adequately pinpoint who is most at risk. For every village suffering from a high rate of suicide, there is a village that has known few or even no suicides. For every young man who grew up in a home plagued by alcohol abuse who takes his own life, there are several young men who grew up in similar homes who are not merely surviving, but living happy, healthy, productive lives.

There is a need for detailed research to help us understand not only the factors that lead to suicide, but also the factors that lead to success. Such research will enable us to isolate the predictors of suicide in a way that makes possible the design of prevention and intervention programs targeted precisely at those most at risk. Such research will enable us to identify and support the elements in family, school community and cultural life that build the self-concepts, the value systems and the social and intellectual skills associated with spiritual and emotional strength and the will not just to live, but to participate fully and joyfully in life.

Research needs are further discussed in the recommendations section.

ALCOHOL AND SUICIDE

That there is a relationship between alcohol abuse and suicide (and other forms of personal and interpersonal violence) is quite clear. However to say that alcohol abuse causes violence and suicide is to oversimplify the complexity of both the relationship and the causes. Alcohol abuse needs to be considered in several ways. It both contributes to and causes personal problems. It damages the sense of judgement and increases the likelihood of impulsive behavior. It also is a symptom of deeper social and personal conflicts.

The relationship can have both a long term aspect as well as immediate and direct effects. Research shows that young people who commit suicide often had profoundly troubled childhoods. Frequently the source of the trouble is the unpredictable and sometimes violent behavior of alcohol abusing parents. Children who grow up in homes free of alcohol abuse are far more likely to learn the life skills needed to be successful and to have positive images of themselves and their worlds.

Young people who commit suicide are also likely to have experienced conflicts with family and societal institutions during adolescense. The likelihood of such conflicts is increased if the young person is a substance abuser.

People who commit suicide are likely to be intoxicated at the time of their deaths. A study of 36 suicides in the Yukon-Kuskokwim delta over a six year period showed that 72% of all victims were intoxicated at the time they took their lives and 78% of those between the ages of 15 and 24 were intoxicated at the time they died. Would they have committed suicide if they had not been drinking? There is no simple answer. Research tells us that people who commit suicide usually have a lengthy history of problems and have been thinking about suicide for some time. The act, as opposed to the thought, however, appears in many cases to be impulsive and facilitated by intoxication.

Public testimony summarized later in this report indicates that many believe the underlying facts which contributes to both alcohol abuse and suicide are similar. The disruption of traditional, cultural, social, familial, and economic patterns caused by the impact of a new and different culture's values and lifestyles has contributed to a sense of personal powerlessness and confusion. These feelings lend to self-destructive behaviors such as alcohol abuse and suicide. In this view, alcohol is a form of self medication, a way of temporarily easing the sense of despair. But because alcohol in larger amounts is a depressant, the despair returns even stronger. "I drank to feel better, but I ended up feeling worse." In the end, if you don't feel very good about yourself or your life, you don't take very good care of either. Continued alcohol abuse is one way of not taking good care. Suicide is both the ultimate expression of not caring and a desperate last stand assertion of power and control.

THE CURRENT STATE SYSTEM TO ADDRESS SUICIDE

When faced with the horror of a completed suicide: one often agonizes over whether something could have been done to keep the suicide from occurring. Often, people wish that "the system" could have provided help. The State of Alaska has created a system to respond to suicide attempts. At present, however, it remains inadequate to address the rising incidence of suicidal acts.

The state agency with the primary responsibility for suicide intervention is the Division of Mental Health and Developmental Disabilities (DMHDD) located within the Department of Health and Social Services. This division funds 27 community mental health centers and provides grants to several other agencies located in urban and rural Alaska. All community mental health centers are required to provide 24 hour on-call services for emergencies such as suicide. Several local crisis lines and one statewide line are also funded by the division. The Alaska Psychiatric Institute is directly managed by the DMHDD and provides 24 hour psychiatric inpatient services for persons who are in imminent danger to themselves or others due to emotional problems. Many suicidal people are sent to Alaska Psychiatric Institute from around the state for evaluation and treatment. The DMHDD also provides funds for local hospitals in Fairbanks and Sitka who have agreed to become designated facilities. As part of designation, these hospitals will provide care to suicidal people. All who receive funds from the DMHDD are required to serve people in need regardless of their ability to pay.

The services currently provided by the DMHDD seem to be inadequate for several reasons. First, many people do not know local agencies exist and can provide help for suicidal people. Second, local agencies may be located many miles away from the suicidal person, making timely response impossible. Third, persons who work for the agencies are often overwhelmed by the number of persons and problems they are dealing with and do not engage in work to prevent suicide as prevention is a lower priority for service than direct emergency care.

Other state funded agencies are often called upon to intervene in critical situations relating to suicide. State troopers and Village Police Safety Officers (VPSO) are often asked to take temporary custody of persons and to place them in a setting in which they are not dangerous to themselves. Staff of the Division of Family and Youth Services may be asked to intervene in critical situations, though their mandate does not include this type of service. The Council on Domestic Violence and Sexual Assault has also been involved in working on issues in suicide.

The large association of alcohol and drug abuse with the occurrence of suicide in the state necessarily introduces another system, the State Office of Alcohol and Drug Abuse (SOADA). Since this system provides for people with or susceptible to drug and alcohol problems, it therefore has a cliental in part of people at risk. The system provides a full range of prevention, intervention and treatment services.

The prevention services rely on educational and training activities. Included are programs with school districts that seek to enhance positive attitudes, values and behavior in which alcohol and drug abuse is unacceptable.

Intervention services seek to identify persons in need and encourage them to enter and accept treatment. The treatment programs provide a variety of rehabilitation and counseling services for drug and alcohol abuse. In addition a network of volunteer groups, such as Alcoholics Anonymous, provide additional support and post treatment.

The fact that these agencies have responded to the need to address suicide is evidence of the overwhelming need for services and the compassion of many people in our human service system. However, it often creates a confused, patchwork approach to the problem.

Although not part of the formal system intended by law to address suicide issues, the schools of the state have become engaged with the problem. Few school districts in Alaska have escaped the tragedy of a suicide occurring among their students. Those who have experienced an attempted or completed suicide have taken the initiative of seeking avenues to prevent future attempts and to help the school community understand and grieve the tragedy in a constructive manner. It has been because of the concern of a particular teacher, counselor, administrator, or other individual that schools and school districts have taken measures to train staff and offer instruction to students.

Schools have taken upon themselves the identification and referral of students who have demonstrated suicidal tendencies to mental health counselors where they are available. They have held school assemblies after a suicide or violent death to help the student body deal with the loss of a fellow classmate. School counselors, where available, have worked with crisis intervention programs and some districts have trained teachers and administrators to be site counselors in rural schools. Out of an individual interest, teachers have developed curriculum for their classroom, and have been trained in dealing with death and dying -- all in hope of preventing a classmate or friend from committing suicide.

Unfortunately, these attempts have been fragmented. Unless there is a committed school board, administrator, counselor, or teacher to see that these efforts are continued, they soon go by the wayside.

It should be noted that many, if not most, suicidal people are seen outside the state system. They may talk to a minister, spouse, friend, or other acquaintance in whom they have some trust and confidence. They may be seen in the emergency room of the local hospital. Research is providing mounting evidence that those experiencing severe problems, such as suicide, would rather go to someone known and trusted than to contact an outside agency. It is most often family or acquaintances who contact outside agencies once the situation becomes critical.

FINDINGS FROM THE PUBLIC HEARINGS

The Committee conducted seven public hearings throughout the State in the Fall of 1987. In Fairbanks six persons, mostly health care providers or administrators, testified. At the Bethel hearings, held in conjunction with the Yukon-Kuskokwim Mayors conference, seventy to eighty people listened to a panel discussion, question period and formal testimony from service providers and village residents. At hearings in Sitka before a meeting of regional health care groups, seventeen providers and administrators addressed the committee. In Kiana where the hearings were part of the agenda of the North and Northwest Mayors Conference, thirteen village residents, high school students, human services providers and teachers offered testimony, while an additional forty to fifty people listened. In Anchorage, hearings were held in conjunction with the annual meeting of Alaska school administrators. After a panel discussion and question period, eleven educators from many different parts of the state addressed the Committee. Also in Anchorage a joint hearing was held with the Governor's Interim Commission on Children and Youth. Thirty parents, health and human services providers, teachers, and students testified. The final hearing took place in Sitka where the committee heard testimony from twenty to thirty students at Mt. Edgecumbe High School. The Committee also accepted written testimony from persons unable to attend the hearings.

In opening each hearing the Committee asked that persons testifying address the issue of the prevention of suicide: what programs currently in place seem to be effective; what needs to be changed; what new programs and efforts are needed. The testimony reflects this "what we can do" focus and offers many concrete suggestions for the prevention of suicide. This section summarizes the testimony and notes the themes and variations in comments and recommendations from various parts of Alaska. It is divided into four broad areas: the context in which people from urban and rural areas view suicide; health and social services delivery systems; prevention and treatment services and service barriers; and research and data collection. All phrases in quotation markers are verbatim from the hearing transcripts and written testimony.

The Context

Those testifying from an urban frame of reference were chiefly concerned with suicidal behavior among adolescents. They viewed the high school as the "front line of defense" against suicide.

Rural residents tended to see self-destructive behavior as a symptom of the intense problems created for individuals, families and villages by rapid and dramatic changes in cultural systems and lifestyles. While agreeing that some suicide prevention activities should take place in the high school, they saw the community as the critical institution in suicide prevention. This difference is reflected in the specific suggestions for new programs and for changes in the way in which some of the services of the Department of Health and Social Services are delivered. Urban residents focused on programs in the high school and on changes in the interface between the school and the various health and social services agencies. Rural residents emphasized programs in the villages and increased community control of services.

Urban and rural residents agreed that substance abuse plays a significant contributing role in the problem of suicide, and that treatment programs for troubled youth are too few and too expensive.

Urban

Urban focused testimony suggested three general areas in which new programs or changes in current procedures are needed. First, troubled youth need to be identified sooner. Suggestions here included various kinds of training for teachers, making suicide education a part of the high school curriculum, programs that build on the skills of peer "natural helpers."

Second, it has to be made easier to get troubled youth the help they need. Educators and parents were sharply critical of what they see as the lack of coordination and major services gaps among the various helping agencies.

Third, schools must be prepared to assist students (and staff) with the strong and painful feelings caused by any sudden violent death of a member of the school community. Teacher training and the development of school-community crisis response teams were suggested.

Rural

Many of those testifying about suicide in rural Alaska discussed the need to see suicidal behavior in the context of the cultural, social, family and economic stresses that currently exist in many villages. Suicide as a symptom of family and community dysfunction was mentioned by service providers, adults and youth at each of the hearings. By weaving the testimony together the following picture of the way in which people view suicide, specifically suicide among Alaskan Natives emerges. Rapid change in cultural patterns and values combined with an enforced decline in subsistence activities and increased pressures to take part in the cash economy have disrupted traditional relationships and patterns of village life. Elders and youth often no longer speak the same language. Many youth seem to have little desire to live in the same ways as their parents and grandparents and may see the activities and opportunities available in small communities as too limiting. The connections and communications between generations have become strained or broken.

This is a painful situation for both young and old and many of those testifying expressed the view that alcohol is used in an effort to escape the pain, stress and frustration created by "massive cultural dislocation." The abuse of alcohol further weakens the bonds of family and community by destroying communications within families and communities, by increasing the incidence of violence and of child neglect and abuse, and by damaging the individual and community sense of self-esteem.

Testimony offered by the students at Mt. Edgecumbe described children growing up in families which they perceived as failing to offer needed attention, direction and feelings of love. Adults testifying in Bethel and Kiana spoke of young people "not knowing who they are," of conflict between home values and school values, of Elders who want to help but, burdened with pain of their own, find it difficult to make contact with young people. Youth blame the parents and Elders for abandoning them in a contradictory world of confusing paths, many deadends and the too easy availability of the false comfort of drugs and alcohol.

In the view of those testifying, the heavy use of alcohol and drugs adds to the sum of despair, and thus directly contributes to suicide. While suicide is an individual act, it is also "really beyond the individual because it is in the environment," in the "social and emotional dysfunction of families and communities." "Suicide is a family disease." "We cannot divorce such problems as suicide from the social conditions that produce an environment conducive to the problem."

Health and Social Services Delivery Systems

Rural

This is the area of recommendations in which rural Alaskans see the possibility of addressing the larger context in which they place the problem of suicide. In both criticisms of the current approach and suggestions for improvement, there was a striking similarity in the testimony from hearing to hearing. Village residents and rural service providers and administrators use similar terms to define the problems and make similar suggestions for solutions.

Testimony suggests a general feeling that the current model of human services delivery to Alaskan villages is not working. This model was described as relying heavily on itinerant, non-Native professionals based in regional hub communities. These professional are employed by different divisions within the State and Federal government. Each division has its own statutory authority which limits who can be served, how services can be offered or/and imposed and for what specific problems.

Many criticisms of this approach were offered. The use of itinerant professionals has not proven effective. They do not understand the culture, relationships, or values of the communities they serve, in part because the itinerant model and heavy workloads do not allow them enough time in any one community. As a consequence they remain little known and less trusted. In a crisis, they are usually not available in time to be of real help. The fragmentation of human services among various agencies creates confusion among those who want or need the services. Statutory limits and lack of inter-agency coordination create situations in which those who need help don't qualify to receive it or are shuffled from agency to agency.

Village residents testifying in Bethel and Kiana stated that the time has come for the villages to take the responsibility for healing themselves and that village people must be trained to do the work. This healing must occur at the individual, family and community levels and must look to the Elders and the culture for strength and wisdom. The State's role should be facilitative, providing on-going funds to village and tribal councils for locally determined, directed and staffed programs and providing technical assistance and training as the villages request.

Rural service providers and educators echoed these statements, calling for the development of a system of village mental health aides, counselors and outreach workers, who would provide intervention, counseling and follow-up services within their own communities and who would work with village councils to establish a variety of village-based education and prevention programs. One person testifying suggested a model in which regional community development workers, local residents, would train and assist village community development workers in the organization and development of village resources to address the full spectrum of emotional, behavioral, family, and socio-economic problems. "Policy makers must realize that economic development, local hire, local control of schools and communities, the future of subsistence and a sense that local people can control this, all of these impact the emotional life of people."

Testimony suggested a number of system change alternatives to facilitate this community-based, broadly defined approach to change and healing. Rather than offering a series of "specialty shop" programs, as one for substance abusers, one for the prevention of substance abuse, one for suicide attempters, another for abused children, and so on, the Department of Health and Social Services should allow villages to opt for a "general store" approach, one program funded to provide whatever mix of services a village determines it needs. Block grants, with the statutes to support the full integration of funds, regulations and services, were cited as a means of accomplishing this.

Other testimony suggested that an "Office of Rural Health" should be developed to administer this new, integrated approach to supporting village-based programs.

Urban

Testimony from urban parents, teachers and service providers make it quite clear that service gaps and lack of inter-agency coordination are very much urban issues as well. "Many of the community agencies are so busy competing with each other for the limited dollars that the ability of those agencies to work together is decreased." Complaints that services are too fragmented and agencies are too turf conscious were common. Specific ideas for reform in the urban context were less common, but the general suggestion that the Department of Health and Social Services needs to provide direction to resolve the problems was made by many.

Specific suggestions for system changes in an urban context included: "Each school needs one local lead agency identified to them by the Department of Health and Social Services that will serve as the point of intake/contact for these youth in crisis;" and the creation of a special commission to design and oversee the coordination of services and the development of clear service system entry points.

Prevention and Treatment Services

This section lists and briefly describes the many ideas for suicide prevention programs presented to the Committee. Prevention and intervention programs are divided into those that are based in the community and those that are based in the school. Programs for the treatment of suicide attempters are discussed separately.

Community Based Programs

The "natural helpers" within a community should be identified, trained, and supported by the mental health professionals working in the region. Mental health professionals should be trained in this community oriented approach to service delivery, trained to recognize and work with community strengths and natural support systems.

One example of this approach is the development of community crisis response teams, trained and ready to intervene to prevent suicide and to assist those affected by the suicide or suicide attempt of a friend, relative, or classmate. Crisis response teams currently function in some villages in the Tanana Chiefs' region and in the city of Fairbanks.

More follow-up and support services for persons returning from treatment need to be available in the smaller communities. Health aides and village public safety officers should be trained to intervene in mental health crisis situations.

Communities should have various kinds of support groups for persons at risk, persons who have lost someone close through suicide, and for suicide attempters. These groups can effectively be run by lay persons, supported and assisted by mental health professionals as needed.

Various kinds of community education programs and workshops were cited as significant steps towards suicide prevention, include classes in parenting, (several parents mentioned the ToughLove Program), and open discussions of the causes and warning signs of suicide.

Youth groups were frequently mentioned. Important elements noted for youth groups include: recreation; skills training; community service; activities that challenge youth and promote growth; activities that transmit cultural knowledge, particularly through the involvement of Elders; activities that teach entrepreneurial skills.

Many persons testifying from the smaller communities spoke of the need for places where youth and Elders could meet. Mt. Edgecumbe students were particularly outspoken in their comments about the absence of activities and facilities for youth in the villages from which they came.

School-based Programs

Youth are more likely to talk to their friends about their feelings and problems than they are to talk to a teacher, counselor or parent. The ability of friends to help friends can be enhanced through appropriate training and support programs. Natural Helpers and Peer Counseling programs have proven effective in many schools in Alaska and should exist in all junior and senior high schools.

Junior and senior high schools should include suicide prevention education in their curricula. Teacher-ready materials should be developed and made available to all schools. Schools should bring community members and mental health professionals into the classroom to discuss suicide and suicide prevention. This program should include recognition of warning signs, how to help a friend, when and who to call for professional help. Teachers should be trained in suicide prevention. This training might include: recognition of suicide warning signs; intervention and referral of students perceived to be at-risk; psychological first aid; appropriate crisis responses. It was suggested that such training be incorporated into teacher training programs at Alaskan universities and included in in-service trainings. There was some feeling that such training should be mandatory.

Some of those testifying stated that schools need to have psychological counselors on staff. Others suggested that one staff member from the local community mental health center might be assigned to work in the school. Most educational personnel testifying agreed on the urgent need for greater cooperation between school staff and the various agencies of the Department of Health and Social Services.

Young adolescent males, particularly Native males, need greater exposure to appropriate role models. Schools should develop programs which bring such role models into the classroom to conduct small group discussions with male junior and senior high school students.

Schools should offer classes designed to promote self-esteem while teaching specific life skills such as problem solving, interpersonal communications, parenting, etc.

Crisis lines should be made more accessible to students and young people.

Learn Alaska, particularly the Talk-Back Program, was cited as a valuable means of sharing information and promoting discussion in the schools. The DRAM-EDY program won high praise from a group of Anchorage teens who testified to the program's helping them survive and resolve painful experiences and emotions.

Treatment Programs

Many people testified that there are not enough treatment programs for children and youth in Alaska. Treatment programs for substance abusers, suicide attempters, specialized group and foster homes able to create safe caring environments for troubled children and teens were all cited as being needed.

Existing treatment programs are too expensive. Health insurance frequently does not cover costs of mental health treatment. Mental health coverage should be made mandatory in all group insurance policies in Alaska.

Residential treatment facilities should be available in all hub communities in the state.

Intervention and aftercare services need to be more widely and more readily available. There are too few programs which offer these services and those that do are frequently understaffed.

Treatment programs for suicide attempters need to be available in jails and prisons. Correctional staff need to be trained in suicide prevention.

There should be statutory changes that make it easier to get people into treatment. Those testifying on this subject suggested the following: a broadening of the categories of children and youth that the Division of Family and Youth can serve to include young people who are in need of treatment but not abused or neglected; a loosening of the mental health commitment law to make it easier to impose treatment on those who are unwilling but in need; changes that insure that the person who is intoxicated and suicidal does not slip through the cracks between mental health and alcohol agencies.

Research and Data Collection

While marked improvements have been made in the state's vital statistics, suicide, particularly in rural areas, continues to be underrecorded. Continued attention needs to be paid to procedural changes within the Bureau of Vital Statistics.

One or more field representative positions need to be established within Vital Statistics. Field representatives would travel throughout the state to check coroner data and to provide needed training to those responsible for collecting and maintaining data in the field. This would help insure the more timely receipt of more accurate data by Vital Statistics.

Vital statistics should develop a worksheet to accompany the death certificate in all coroners' cases. This worksheet, completed by the coroner, would provide data normally not available on the death certificate, particularly regarding alcohol and drug blood levels.

Despite the amount of research completed on suicide in Alaska, the precise targeting of suicide prevention efforts continues to be hampered by the lack of specific information about the who, where and why of persons at risk. Both epidemiological research, particularly focussing on the variation in the rates of suicide across villages and regions of the state, and etiological research are needed. Among the various research topics suggested are: rural adolescent and young adult development; family patterns among well adjusted and troubled rural youth; case studies, often termed psychological autopsies, of persons who complete suicide; an examination of the suicide cluster phenomenon.

The state should fund various suicide education and intervention demonstration projects with carefully built-in evaluation designs to insure that results can be compared and the more successful models promoted.

FINDINGS AND RECOMMENDATIONS

The public testimony we heard and the written reports we reviewed are remarkably consistent in their framing of the problem, in their perceptions of the weaknesses of many of the past and current efforts to prevent suicide and treat suicide attempters, and in their statements about what needs to be done. Many spoke of a need for a deeper understanding of the factors that contribute to suicidal behavior and a need to be able to more accurately determine who is most at risk.

But most who spoke stressed the importance of immediate action -- of doing something now. They called for the creation of new programs and the strengthening of existing programs to assist those in immediate danger and those who are at risk.

Through our review of the studies and testimony, we identified five major themes that demand the attention of policy makers and all Alaskans.

First, the schools have critical roles to play in educating people about suicide, in the early identification of persons at risk and in making connections between troubled youth and persons who can help. These roles are best played by the people in the schools - staff, faculty and students.

Second, the prevention, intervention and treatment programs currently provided by the State of Alaska are overly fragmented. The various human services agencies are too often understaffed and overburdened with restrictions regarding whom they can serve and how they can serve them.

Where there should be cooperations among service providers, there often is competition. Where there should be a safety net for troubled Alaskans, there are holes through which far too many fall.

Third, the problem of suicide in the villages of Alaska is rooted in the complex stresses that exist within rural communities, cultures, families, and individuals. Efforts to prevent suicide must be willing and able to address the problem in all its dimensions and to recognize the relatedness of suicide to other forms of violent, unnatural death, and self-destructive behavior. Rural Alaskans feel strongly that efforts by "outside experts" have too often proven ineffective. The time has come for us to encourage and support initiatives and efforts from within the communities.

Fourth, there are not enough treatment programs to assist those most at risk. Those that do exist are not necessarily in the right location and charge fees that the average Alaskan cannot afford.

Fifth, there is a need for more information and better handling of the information that is collected.

As all of the foregoing makes plain, the issues this committee has sought to address are exceedingly complex. Acknowledging this, and attempting to respond to the cries for immediate help, the committee has not addressed in this interim report all issues and needs; it has instead striven in this to reach conclusions, identify promising avenues for action now, and to ask two departments to provide information to allow the committee to continue its task of developing recommendations for the consideration of the Senate.

It is our intent that the recommendations in the final report be specific, practical, and state clearly how and by whom they should be implemented and at what cost. For this reason the recommendations that follow are presented in the form "findings, recommendation, request." The findings reflect the public testimony we heard and the literature we reviewed. The recommendations reflect our conclusions about the kinds of programs and policy changes that need to be undertaken now to reduce the number of lives lost through suicide and, further, to support and assist village efforts to build the kinds of communities in which people want to live. The requests are to two state departments to provide this committee with specific descriptions, including plans and cost estimates, of how the recommendations can be implemented.

FINDING 1.

The schools are an appropriate focal point -- especially in urban areas -- for direct efforts to prevent suicide. There are various ways in which the ability of schools to fulfill this role can be enhanced.

Recommendation 1.1

Each school needs to identify and implement a mechanism for identifying seriously troubled youth and referring them to the appropriate helping agency.

Recommendation 1.2

Each school should develop a crisis response plan and a trained crisis intervention team which includes school personnel and community helpers.

Recommendation 1.3

Each high school and junior high school needs to include in its regular curriculum a program in "emotional survival skills" that is developed to help young people understand and constructively cope with stress, negative feelings, and difficult decisions. It is in the overall context of this program that youth should be informed about suicide, its warning signs, appropriate ways to support a troubled friend and when and whom to call for professional help.

Recommendation 1.4

Young people are mostly likely to share their feelings and problems with their peers. The ability of peers to support and assist each other can be enhanced through special training. The Natural Helpers program has proven effective in identifying and training peer support networks when on-going, consistent adult support and guidance is available. The Department of Education needs to encourage all high schools in Alaska to implement the Natural Helpers Program and to formalize the role of the adult staff member who supervises the program.

Request

This committee requests the Department of Education to submit to this committee an implementation plan and cost estimates for recommendations 1.1, 1.2 ,1.3 and 1.4 by February 8, 1988.

FINDING 2.

Earlier identification and referral of troubled youth by school personnel will only prove effective if significant improvements are made in the communications and relationships between the school and the agencies to which referrals are made and in the capability of those agencies to respond promptly and appropriately.

Recommendation 2.1

The Department of Health and Social Services needs to develop policies which clearly define the responsibilities its agencies and the procedures to be followed by those agencies when a school refers a youth they have identified as seriously depressed and potentially suicidal. The Department needs to designate one local lead agency as the point of intake for such referrals and identify that agency to the school.

Request

The Committee requests the Department of Health and Social Services to develop and submit to this committee an implementation plan and cost estimate for Recommendation 2.1 by February 8, 1988. The Committee requests the Department to review and refine the plan with the Department of Education prior to its submission.

FINDING 3.

The numerous social and human services programs provided by the State of Alaska have not proven effective in the villages of the state. The division of responsibility among the various agencies of the Department of Health and Social Service and the reliance on models of intervention and treatment developed by and for a different culture in a different setting have severely limited the agencies' ability to relate to the complex reality of rural problems. The use of itinerant service deliverers has meant that help is rarely in the right place at the right time.

Service providers and the rural communities of Alaska agree that the State needs to alter its policies to allow greater control of program design and service delivery by the communities themselves.

Recommendation 3.1

The Department of Health and Social Services needs to develop a rural human services program based on the concept of integrated community development. This concept requires that the community that has the problem must have the freedom and ability to define that problem and to develop and implement its own solutions. It is in this manner that the inter-relatedness of individual, social, cultural, spiritual and economic problems is best addressed. The role of the State of Alaska in the community development model is to provide flexible, non-categorical funding, technical assistance, training and professional consultation as the communities request with reasonable quidelines which insure critical health and safety needs are met.

Request

The Committee requests the Department of Health and Social Services to submit to this committee a plan and cost estimate for the implementation of recommendations 3.1 by February 8, 1988. The plan should consider the structural and statutory changes necessary to fully implement a community based rural human services program including the development and administration of the unified human services block grant program for rural Alaska.

FINDING 4

The residential treatment programs for youth at serious risk are too few, too expensive, and poorly distributed across the state.

Recommendation 4.1

The state needs to develop a more equitably distributed network of residential treatment programs for seriously troubled youth. Particular attention needs to be paid to locating programs in rural hub communities and to working with the regional catchment area to insure the programs reflect the ethic of the people they are meant to serve.

Request

The Department of Health and Social Services is asked to submit to this committee a plan and cost estimates for the development of a statewide network of residential treatment facilities to serve those youth most at risk for suicide. The department is further asked in its submission to describe means of making such programs more affordable, including a discussion of the benefits and problems involved in seeking to make mental health coverage a mandatory component of health insurance.

FINDING 5

There is a continued need for careful epidemiological and etiological research designed to produce the kinds of information needed to more accurately identify persons at risk and prevention and intervention programs that work. Research also needs to focus on identifying the factors that contribute to healthy development and effective coping skills. Continued attention needs to be paid to improving the collection and recording of vital statistics.

Recommendation 5.1

Funds should be provided to support a well-considered, coordinated research effort designed to provide human service agencies with data on which effective programs can be based.

Recommendation 5.2

The Bureau of Vital Statistics should institute a field program to ensure data quality and to provide training to all persons who collect and provide vital statistics data.

Recommendation 5.3

The Bureau of Vital Statistics should pursue and institute a supplementary vital statistics form to supplement the death certificates in all coroner cases and should receive maximum input from professional research personnel in the development of this supplementary form.

Recommendation 5.4

The Department of Health and Social Services must continue its efforts to automate the vital statistics data system and must take whatever additional steps are needed to insure data is collected, coded, recorded and corrected in a timely and accurate manner.

Request

The Department of Health and Social Services is asked to submit to this committee an implementation plan and cost estimate for recommendations 5.2, 5.3 and 5.4.

DEPARTMENTAL RESPONSE

Both the Departments of Education and Health and Social Services responded within 22 days as requested and their responses were the subject of a special meeting of the Committee on February 11, 1988.

The Department of Health and Social Services commended the Committee, saying, among other things:

> "The strength of the report findings are amplified because they dovetail with many of the key themes in the Governor's Interim Commission on Children and Youth.
>
> We are reaching a crossroads in understanding both the roots of these problems and the type of delivery systems that are most likely to be successful in reducing them. We are understanding more clearly the need to design an environment where community empowerment prevails. Money alone will not give us the long-term answers."

As requested, the Department also provided implementation plans and estimates of costs as follows:

DEPARTMENT OF HEALTH AND SOCIAL SERVICES	FY '89 (in thousands)
- Redesigning the system	$ 162.0
- Responding to immediate needs (eight villages)	397.0
- Residential treatment	(further analysis required)
- Child and family research	147.7
- Adolescent health survey	133.8
- Data Reporting	171.5
- Data entry	235.9
- Village mental health aides (each village, one-fourth time)	5.9 per village
- Community Mental Health Centers as lead agencies.	1,328.4

The Department of Education also commended the committee, saying, in part:

> "The Interim Report has precipitated much concern and determination to change the circumstances that lead to suicide. Certainly, education has a key role to play in the circumstances that will eventually lead to the creation of an environment that will discourage suicide among our young people.
>
> The recommendations that your committee has asked the Department of Education to develop implementation plans and cost estimates for are very important, and we have prepared a document which is based on

the Department's—response to the GICCY recommendations dealing with suicide.

The Department also provided implementation plans as follows:

DEPARTMENT OF EDUCATION	FY '89 (in thousands)
- Identification of troubled youths; development of crisis report plans	$ 21,259.7
- Life skills curriculum, training	449.5
- Natural Helpers	810.4

The complete responses of both Departments appear in the Appendix.

PUBLIC RESPONSE

More than 400 copies of the Committee's draft interim report were distributed following the meeting of January 18, 1988. Twenty-four letters were received that reflected careful review of the report.

The writers of these reviews and commentary -- providers of services, Native organizations, federal agencies, concerned citizens -- were uniformly complimentary in their reviews, but several also called our attention to underlying factors contributing to suicide or suicide attempts that they believed were ignored or insufficiently described in our report. These were: joblessness among village youth, the high rate of Native failures in urban high schools, the contrasts between life on television and one's own life, the doubts about self-worth a minority person may be led to by the larger society, the disruption in the transmission of parenting skills, Native traditions and subsistence skills caused by the imposition of boarding school education prior to the Molly Hootch Act, the experiences of prison life, and the economic pressures (such as child support) upon persons with no income.

Letter writers also pointed to additional remedial actions that might be taken such as education through field-delivered university course work, school courses in Native languages and culture, establishment of youth employment programs, culture-specific alcohol education, reduction of barriers to Native employment in mental health positions, and special training for Village Public Safety Officers and for persons employed in hospitals and regional health corporations.

There was wide agreement that leadership within communities was a critical factor in reducing the stresses that lead to suicide and suicide attempts.

RECOMMENDATIONS

As we note in the report itself, the complexity of the issue this committee faced was even greater than anticipated. This complexity, together with the press of the legislative session, led us to narrow our task to one of making recommendations to the Senate that give promise of producing positive changes soon. Secondly, we evaluated proposed actions to see whether they would be clearly consistent with the public and professional concensus we had heard. Finally, but regrettably necessary, we weighed the cost of proposals against the availability of revenues in the current year. What is presented here offers a balance of effort between departments of state government and their client service delivery organizations that encourages and assists the implementation of locally designed programs of suicide prevention and intervention.

Based upon the foregoing, we have concluded that three goals must be pursued now.

A. Improving the ability of communities to assist persons at risk.

1) The Department of Health and Social Services should be instructed (by legislative intent) to seek ways to provide flexible, non-categorical funding and to reduce fractionalization of program delivery, particularly for rural areas of the state, through consolidation, re-structuring or redesign of existing grant programs. The department should report to the next session of the legislature on the progress of this activity.

2) The Department of Health and Social Services should be instructed (by legislative intent) to establish a broadly experienced crisis intervention/training assistance team from personnel within agencies such as State Office of Alcohol and Drug Abuse (SOADA), Division of Mental Health, and Division of Family and Youth Services to assist community based program development.

3) The legislature should redefine "mental health professional" to include a trained community mental health aide for rural areas that do not have and are not likely to attract highly trained specialists.

4) The legislature should appropriate to the Department of Health and Social Services undesignated funding in the amount of $900,000 to be used as grants to community and regional organizations for crisis response, community based program development, and pilot projects in suicide prevention and intervention.

5) The legislature should appropriate $150,000 to the University of Alaska to help defray the costs of providing field training of persons associated with suicide prevention and intervention, such as public protection officers, hospital personnel, social workers, teachers, counselors, correctional system personnel and community mental health aides.

B. Helping assure that schools are prepared to assist in the prevention of suicide.

1) The legislature should provide funds in the amount of $500,000 to the Department of Education for grants to school districts to be used for the establishment, training and supervision of natural helper (peer group) programs in at least ten districts in cooperation with the Department of Health and Social Services.

2) The legislature should provide funds in the amount of $200,000 to the Department of Education for adaptation of life/coping skills curricula by school districts to their local needs. These funds should be disbursed as grants to at least ten school districts proposing innovative and relevant coursework appropriate to their areas.

3) The legislature should appropriate $200,000 to the Department of Health and Social Services to provide mental health lead agency services through local or regional client organizations, to school districts with suicide crisis intervention and prevention programs.

4) The legislature should require (by legislative intent) that all school districts report by November 1, 1988 to the Department of Education and this committee on their progress in devising programs or other actions to prevent suicide and otherwise assist youth at risk.

C. Improving our knowledge of the scope and severity of the problem.

1) The legislature should appropriate $235,000 to the Department of Health and Social Services to increase the accuracy, reliability, detail and timeliness of the Division of Vital Statistics reports on the occurrence of suicide and other violent death.

2) The legislature should appropriate $134,000 to the Department of Health and Social Services for the Adolescent Health Survey.

3) The legislature should appropriate $75,000 to the University of Alaska for research that would identify individual and community characteristics of suicide occurrences in rural Alaska.

While we make no specific recommendations regarding alcohol and drug abuse, we acknowledge the close association between these substances and most suicides and suicide attempts. We therefore urge the legislature give priority consideration to pending legislation that gives promise of reducing alcohol and drug abuse.

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APPENDIX

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

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JUNEAU, ALASKA 99811-0601
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February 11, 1988

The Honorable William L. Hensley
Chairperson, Senate Special Committee
on Suicide Prevention
Alaska State Senate
P.O. Box V
Juneau, AK 99811

Dear Senator Hensley:

The Department of Health and Social Services is pleased to respond to the Interim Report of the Senate Special Committee on Suicide Prevention. First, I would like to commend the Committee for your thoughtful and meaningful work on this issue. I believe this effort will provide the impetus needed to focus our efforts at preventing the tragic rate of suicidal deaths in our state, much the same way the Governor's Interim Commission on Youth and Children (GICCY) report has focused our attention holistically on the issues impacting Alaskan children.

The themes in the report address the inextricable relationship between suicide, family dysfunction, personal violence, alcohol and cultural change; recognizing the significant role the community and family must play in the resolution of these issues. The strength of the report findings are amplified because they dovetail with many of the key themes in the Governor's Interim Commission on Children and Youth work.

We are reaching a crossroads in understanding both the roots of these problems and the type of delivery systems that are most likely to be successful in reducing them. We are understanding more clearly the need to design an environment where community empowerment prevails. Money alone will not give us the long-term answers. We cannot buy our way out of these problems by simply treating more victims.

In this spirit, we are going to try to find a way to change our grant programs. Our goal is to remove the artificial barriers that exist among the various programs and to allow communities to design their own programs using the resources of each grant program without having to prepare multiple, difficult applications. We do not know, until we start, how possible this is.

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Common sense says it should be possible. We are going to use that common sense, the advice we will seek from a variety of sources, and our own creativity and commitment to go as far as we can.

We will have to share this task with the advocates for the various programs and special needs populations and the regional health and social service providers. Their support is essential in this project or it will certainly fail to achieve its potential.

The Department would like to continue a close working relationship with the Special Committee on Suicide Prevention to further develop these ideas and the specific implementation plans and costs contained in our response to your work.

Sincerely,

Myra M. Munson

Myra M. Munson
Commissioner

Enclosure

DHSS RESPONSE TO
INTERIM REPORT OF THE
SENATE SPECIAL COMMITTEE ON
SUICIDE PREVENTION

RECOMMENDATION 3.1 - Develop a rural human services program based on the concept of integrated community development.

DHSS IMPLEMENTATION PLAN

Suicide prevention and the delivery of rural services share commonalities that suggest their implementation be interwoven. The thread of commonality lies in recognizing the role of community in the healing process. Recommendation 3.1 suggests a redesign of parts of the present delivery system in rural Alaska, as well as a need to enhance available support/counseling services to help prevent suicide. Immediate Rural service needs must be considered, with programs developed in tandem with needed changes in the state system. The following implementation strategies are suggested.

Addressing the State System

What is needed is not a great deal of money, but a great deal of work in bridging the boundaries that have traditionally separated rural communities and state government. This work must determine the mechanisms needed to change government program and funding systems to be more responsive to identified needs in small communities rather than forcing communities to respond to government.

To accomplish this goal, a commitment must be made over time by the government, regional systems and local communities. During the initial phase of three years, there must be a thoughtful blend of analysis, listening, and planning to allow for careful long-term action. The resulting system will spring from what is learned through this process, allowing for needed change that is owned by participating systems.

The Workhorse

It is painfully clear that the resolution of rural community suicide is well beyond the control of any state agency, including DHSS.

A Council of Advisors is proposed, comprised of nine people who have shown interest in finding new ways of addressing rural social problems. They would represent Native needs, organizations and state government. Their work would be supported by staff within the DHSS Commissioner's office.

The Council of Advisors would provide a forum for review of present structures of government and their relationship to community development. This review would include analysis of DHSS regulations and policies including their relationship with the departments of Community and Regional Affairs, and Commerce and Economic Development and others.

It would conjointly look at community development approaches in the health/social fields, economic development (i.e. fisheries) and Native American culture.

The councils first year goal would be to design and suggest a new system integrating their analysis into an action plan that would enhance the community as healer. The plan would define those highly technical clinical services that must continue to be made available and how the community will access them.

The Immediate Needs

Concurrently, immediate rural service needs must be addressed. The GICCY recommended that basic counseling services should be available in all Alaskan communities and suggests that existing community workers, such as a health aide, VPSO teacher can, with support and consultation, form the nucleus of a local response team. Results of Division of Mental Health and Developmental Disabilities' pilot projects in several villages support this view. In some communities such response teams have formed and are intervening in crisis situations. Some communities have other ideas about what they can do to address the issues that contribute to the loss of hope among their residents and can define what services they need. These communities often need relatively small amounts of financial support and technical assistance to carry out their plans and strengthen their core services.

To achieve this goal of community empowerment departmental discretionary funds to support local efforts would be needed. These efforts might include various programs developing out of the community planning for their own needs. For example, paying a local person to work as a youth counselor or hiring a trainer for the village crisis response team. Technical assistance will be available to communities through a Community Development Specialist within the Division of Mental Health and Developmental Disabilities, which is included in the Governor's FY 89 proposed budget. Contracted regional community development specialists would also be used.

Technical assistance might include assisting communities to define and develop a planning process; assisting with funding applications, budget estimates and other administrative matters; assisting with the identification and location of needed additional resources, and developing protocols for basic mental health services.

To be successful, local communities and relevant local and regional entities, i.e., the Community Mental Health Center, the regional health corporation, the IHS, and the school district must participate in this collaboration.

The experiences of these discretionary projects would provide valuable knowledge and testing grounds for the Council of Advisors in their work, and enable the department to make needed systems changes.

Cost Estimate

A. Redesigning the Future System

	FY 89	FY 90	FY 91
Council of Advisors			
Travel and per diem	60,000	40,000	20,000
$10,000 x 6 meetings			
Personal Services			
Program Coordinator (R20)	59,888	59,888	59,888
Clerk IV (R9)	28,626	28,626	28,626
Total Personal Services	88,514	88,514	88,514
Travel and per diem			
15 trips x $750	11,250	11,250	11,250
2 days x 15 x $80/day	2,300	2,300	2,300
Total Travel Expenses	13,550	13,550	13,550
Total	162,064	142,064	122,064

*All other administrative costs will be incurred by DHSS

B. Responding to Immediate Service Needs

Discretionary Funds			
25,000 to 50,000 x 8 villages	300,000	400,000	600,000
Contractual Services			
Community Development Specialists	35,000	35,000	35,000
Travel and per diem	11,250	11,250	11,250
15 trips x $750			
2 days x 15 x $80/day	2,300	2,300	2,300
Total Travel Expenses	13,550	13,550	13,550
Total Contractual	48,530	48,550	48,550
Total Recommendations	397,080	497,100	697,100
TOTAL	559,144	639,164	819,164

RECOMMENDATION 4.1 - Equitably distributed network of Residential Treatment programs for seriously troubled youth.

This finding is similar to the Governor's Commission on Children and Youth (GICCY) recommendation referencing the need for more residential treatment options for substance abusing youth. Presently, the State Office of Alcoholism and Drug Abuse (SOADA) funds ARCH, a residential facility in Anchorage. There is a continual waiting list for these 16 beds. Through federal 99-570 funds, the Indian Health Service has been awarded $469,000 to establish one residential substance abuse treatment facility for Native youth. In Kodiak, another residential treatment program is starting up. Even when these programs are operational there will likely be a need for more treatment beds. Building new facilities is not the answer. Resources could be added to existing residential facilities around the state to address the needs of these seriously troubled youth, as a cost-effective strategy. However, more departmental work is needed before a final implementation plan or cost estimate is offered to the Committee.

RECOMMENDATION 5.1 - Coordinated research to provide effective human service agencies with data for program design.

DHSS IMPLEMENTATION PLAN

A. Child and Family Research

This recommendation addresses the critical need to improve the quality and scope of suicide data collection and analysis. The recommendation identifies the need to centralize research activities in order to more efficiently and accurately process information. Additionally it points out the need to capture revenue sources associated with conducting the research and disseminating relevant findings.

High level analysis is needed to meaningfully understand social and health trends and to provide communities the facts needed to make informed decisions on how best to deal with and prevent suicide. The department currently lacks the ability to conduct ongoing, comprehensive evaluations and assessments of data pertaining to children, youth and families.

Additionally the state is losing substantial amounts of federal and private foundation funding which could be used to respond to the problems facing Alaskan children and youth. Past reductions in administrative staff have greatly limited the department's ability to apply for grant funds.

In order to respond to these interrelated problems, the department needs two Research Analyst III's and a clerk typist to conduct ongoing research and analysis. One of the analysts would also be responsible for reviewing, analyzing and assisting in applying for grant funds which are consistent with community and department goals.

Cost Estimate

A. Child and Family Research

	89	90	91
2 Research Analysts	99.2	99.2	99.2
1 Clerk Typist	28.5	28.5	28.5
Contractual	7.5	7.5	7.5
Equipment	12.5	0	0
Total	147.7	135.2	135.2

B. Adolescent Health Survey

No comprehensive survey of Alaska's youth and their needs exists. Program design and resource allocation requires guesswork without reliable baseline data. The Indian Health Service (IHS) will survey this year a representative sample of Alaska Native youth with the Minnesota Adolescent Health Survey. Unfortunately the department does not have the funds to assure that non-Native youth can be added to the representative sample being surveyed by IHS. Through statewide effort, baseline data on a wide range of health, education, and social issues will be available for comprehensive planning, and development of specific program designs responsive to the needs of Alaskan youth, if the full population could be surveyed.

The Minnesota Adolescent Survey is a questionnaire administered to 12 through 18 year olds. The questionnaire asks about a number of health related issues including substance abuse, self-image, relationships, sexuality and diet. The survey instrument has been previously validated, having been administered to over 30,000 adolescents in Minnesota and South Dakota. It was objectively developed for administration through Minnesota by the State Division of Maternal and Child Health, and the University of Minnesota. Approximately 9 other states have contracted with the University of Minnesota for survey usage. The Indian Health Service Headquarters in Washington, D.C. has contracted with the University of Minnesota to survey 40,000 to 50,000 American Indian/Alaska Native youths throughout the United States.

Cost Estimate

B. Adolescent Health Survey

The cost to the state of Alaska to ensure that a statewide sample of Native and non-Native students is surveyed would be $133.8. This would cover the costs of surveying 26,000 students who would not be included in the Indian Health Service survey in Alaska.

Contractual Services

Contract with the University of Minnesota	$85.9
Purchase of Survey	6.5
Computer Time and Data Processing	62.7
Secretarial	5.0
Travel to Alaska	3.5
Supplies/postage/phone	4.0
	81.7
Indirect - 5%	4.1
	85.8
Postage for parental consent forms	20.0
Project Manager (full time for 6 months)	25.0
Travel and per diem (project manager)	3.0
TOTAL	$133.8

RECOMMENDATION 5.2 Field program for quality control and training of all persons who provide vital statistics data.

DHSS IMPLEMENTATION PLAN

This recommendation addresses the critical need to collect and report suicide data in a consistent manner. Consistent collection and reporting of vital events is essential for communities and state policy makers to appropriately respond to suicides when they happen and to reduce the incidence of suicide in the future.

An active field program is necessary to ensure consistent data collection. The major efforts of a field program center around training, problem solving, and auditing of data quality.

The field representatives' entire focus is on the quality of the vital statistics data provided by community officials. In a typical state field program, the field representative spends 60-70 percent of their time visiting hospitals, funeral directors, physicians, coroners and magistrates on a regular schedule. Unannounced visits are also made. The field representatives check certificate data quality by comparing birth certificates with hospital logs, and death certificates with magistrates and coroners' files. They make recommendations for changes in procedure which will standardize and improve the data generated by all sources. Field representatives develop up-to-date manuals to instruct data generators on how to properly complete the certificates. These efforts improve data on suicides, homicides, and accidental deaths.

Presently, there is no field work done in Alaska to audit records for accuracy or completeness, or to statistically correlate the data.

The department needs two field representatives to audit data and provide training. In addition, such staff could present at statewide and regional conferences of coroners, magistrates, physicians, medical records staff, Community Health Aide Directors, Public Health Nurses and funeral directors to teach how to properly fill our birth and death certificates.

This training will be particularly important because the new revised birth and death certificates go into effect January 1, 1989.

Past reductions in research staff have also meant that currently the Vital Statistics Annual Report is being produced by one research analyst and one statistical technician who are also responsible for answering vital statistics data requests. As a result, the report has been published 2-3 years late.

This lack of timeliness in the dissemination of vital statistics data and related analysis has been a source of great frustration to departmental program managers and to health agencies across the state, including the Native regional health corporations, federal agencies like the Center for Disease Control, other state agencies like the Department of Labor, and private citizens.*

Cost Estimate

		89	90	91
A)	Improved Data Reporting			
	2 Field Representatives at $49.6/position	99.2	99.2	99.2
	Travel per diem Field Visits	50.0	50.0	50.0
	Training	9.8	9.8	9.8
	Contractual	5.0	5.0	5.0
	Equipment	7.5	0	0
	TOTAL	171.5	164.0	164.0

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*Data on the patterns of births and deaths in any state are an invaluable and essential resource to use in directing public health efforts. In Alaska, the data are essentially outdated by the time they are released and thus are of little help in planning, prioritizing, and evaluating public health efforts statewide, including departmental programs.

RECOMMENDATION 5.3 - Supplemental death certificate form in coroner cases.

DHSS IMPLEMENTATION PLAN

Death and birth certificate committees have been meeting for the last year to revise these certificates in accordance with the National Center for Health Statistics. The death certificate subcommittee determined that an additional vital statistics form was needed to acquire the desired public health information about deaths. A form has been developed and is currently being reviewed for final revisions. Coroners will be required to file this supplemental form with the death certificate in all coroner cases.

Professional research personnel served on both the death and birth certificate subcommittees, including participation from vital statistics, coroner, medical examiner, public safety, emergency medical services, alcohol treatment, and health science research professionals.

Cost Estimate

No new costs to the state.

RECOMMENDATION 5.4 Automate vital statistics data system and take whatever steps needed to insure timely and accurate data collection.

DHSS IMPLEMENTATION PLAN

The reliability of state vital statistics data has been an ongoing concern of health officials and policymakers. Without reliable data, incomplete information or misinformation goes to departmental management. The lack of valid information leaves management without a basis for important policy decisions necessary to alleviate a major health problem like suicide. Accuracy and timeliness should be the two goals of any state statistics system. The needs identified here, if met, will greatly aid the department in meeting these goals.

Cost Estimate

Accurate data entry and processing of certificate data are essential to ensure that vital statistics data, when released, are valid and reliable. Two data processing clerk positions are needed to ensure accurate and timely review of certificates and querying of data sources for additional information and corrections.

	89	90	91
2 Document Processing Clerks at $32.2/position	64.4	64.4	64.4
TOTAL	64.4	64.4	64.5
GRAND TOTAL	$235.9	$228.4	$228.4

RECOMMENDATION 2.1 - Policy and procedure development for school referral of high risk children and youth by DOE/DHSS.

DHSS IMPLEMENTATION PLAN

According to the mental health statute, A.S. 47.30.545, one of the highest priorities of service by the community mental health centers is a person:

(D) Who is under 18 years of age:

(i) Is at immediate risk of removal from home for treatment of a mental or emotional disturbance;

(ii) Exhibits behavior indicating a high risk of developing a disturbance of a severe or persistent nature.

The Department of Health and Social Services, through the Division of Mental Health and Developmental Disabilities, will designate the community mental health center as the lead local agency consistent with this recommendation. The Department will develop appropriate policies and procedures to be followed by the community mental health centers to effectively achieve in this recommendation.

This recommendation clearly states that the Department of Education and the Department of Health and Social Services have a joint role to play in trying to prevent suicide and rehabilitating recovering attempters and or survivors. The school and the community mental health center must work cooperatively to achieve this goal.

The Role of the School

1. Recognizing the "at risk" signs in students. The assumption is that school personnel are in an excellent position to be among the first to become aware of warning signs of impending suicidal behavior.

2. The school should be able to respond to a crisis. School personnel must be taught techniques of intervening in crisis situations to prevent a suicide or to alleviate the social, cultural, and environmental precipitators of crisis. The Department of Education proposes the formation of core teams within such school to receive crisis intervention training.

3. Establish ongoing liaison and make appropriate referrals to community mental health centers and community-based agencies.

4. The school may provide support and help to the students survivors of a suicide experience.

5. The school should build a positive mental health environment in which each child can learn the skills of everyday life as well as prepare him/herself for the future.

To achieve the above goals, the Department of Education will, subject to funding:

1. Provide school social workers or school counselors in every elementary, middle and high schools in urban areas, and in each rural school district.

These counselors will identify children and adolescents individually and as groups, and provide services as needed; work with school administration and personnel to ensure effective communication and to provide needed resources; work with children who are physically and emotionally handicapped, work with parents by establishing a liaison between the home and the school; and provide information and help parents and students utilize existing community resources.

The Department of Health and Social Services will perform the following tasks, subject to funding:

1. Identify the community mental health center which is responsible for providing services to a particular school and or district.

2. Provide additional resources to community mental health centers so that they can respond effectively to referrals and other contacts from the schools.

3. Take steps to insure that each community mental health center develops written policies and procedures regarding referrals from and consultation with the school. The policies and procedures will establish that the community mental health center will do the following:

a. Establish a liaison with each school in its catchment area.

b. Insure that children and youth referred by the school counselor are seen promptly and that the school counselor is kept informed of the course of treatment as appropriate and within in the limits of confidentiality.

c. Serve as a resource for teachers, school counselors and administrators in areas of behavior management and curriculum development and enrichment as appropriate.

d. Provide the schools with relevant information, consultation and inservice training on various topics including:

improving teacher student relationships;
improving intervention and referral skills;
developing counseling support systems.

4. In rural communities which are distant from the Community Mental Health Center, the community mental health center, school and community will work together to identify appropriate community mental health center, school and community linkages. One possible model is the employment and training by the Community Mental Health Center of a part-time village based mental health aide, in communities wanting to utilize this approach.

Cost Estimate

A. Village Mental Health Aides

One part-time mental health aide in rural communities which are distant from the community mental health base. The decision to employ a mental health aide will be made jointly by the community mental health center, school and village. The total cost is based on the number of mental health aides employed, a number which cannot be determined at this time.

$10/hr x 10 hours/week x 40 weeks =	$	4,000
Fringe at 23%		x . 10
		4,400
Travel costs associated with training, supervision, and intervillage travel $1,500 per mental health aide.	$	1,500
TOTAL COST per mental health aide	$	5,900

B. Community Mental Health Centers as Lead Agencies

One master's level counselor or social worker to serve as designated school-community mental health liaison in each community mental health center at an average cost of $40,000 per counselor.

27 CMHCs x $40,000	=	$ 1,080,000
average fringe at 23%		x. 23
		248,400
		$ 1,328,400

C. Lead School Counselors

The Department of Education has estimated the cost of placing a lead counselor in each of the 55 school districts and Mt. Edgecumbe at	$ 4,200,000
The Department of Education has estimated the cost of placing a counselor in each school (K-12) at	$ 11,000,000
TOTAL COST	$ 15,200,000

STEVE COWPER, GOVERNOR

DEPARTMENT OF EDUCATION

OFFICE OF THE COMMISSIONER

GOLDBELT PLACE
801 WEST 10th STREET
POUCH F
JUNEAU, ALASKA 99811

February 10, 1988

The Honorable William L. Hensley
Alaska State Legislature
P.O. Box V
Juneau, Alaska 99811

Dear Senator Hensley:

First of all, I would like to congratulate you and the other members of the Senate Special Committee on Suicide Prevention for the work that you have done on one of the most critical issues that our Native peoples are facing. The epidemic rate of suicide among the young Native men and women needs to be arrested.

The Interim Report has precipitated much concern and determination to change the circumstances that lead to suicide. Certainly, education has a key role to play in the circumstances that will eventually lead to the creation of an environment that will discourage suicide among our young people.

The recommendations that your committee has asked the Department of Education to develop implementation plans and cost estimates for are very important, and we have prepared a document which is based on the Department's response to the GICCY recommendations dealing with suicide prevention.

In our response to recommendations 1.1 and 1.2 we present six activities. Out of the six, there are three that we feel are of high priority. They are:

Training of Core Teams
Lead Counselors
School Counselor/Village Aide Program

In our response to recommendation 1.3 we present five activities. Out of the five activities, the following three are high priority:

Model Life Skills Curriculum
Training in Use of Curriculum
Parenting and Child Development Courses

Our response to recommendation 1.4 speaks to the establishment of Natural Helper Programs in all the schools in Alaska during a three year period.

5-E1LH

The cycle of learning parenting skills was interrupted when many Alaska Native youth were transported to distant boarding schools throughout the nation. Now the same individuals are adults raising children. Many of them lack parenting skills. In our response to Recommendation 1.3, we have included a component for a parenting and child development course to be piloted in junior high/senior high in four school sites.

Also the Department of Education would advocate the development of a program which will provide training for community persons to become aides to school counselors. The program would be similar to the Community Health Aide program which has successfully trained Alaska Natives as health aides.

I would like to emphasis that the administrative costs that we have presented are essential for the success of each of the programs. Coordination and technical assistance responsibilities from the State level cannot be met without additional expertise on staff.

The job that we have ahead of us is very important and can be done with the right resources and cooperation between all agencies concerned. Suicide is final and affects so many people.

Once again, congratulations on the commendable job that you and your staff have done.

Sincerely,

William G. Demmert
Commissioner

Alaska Department of Education
Response
to

INTERIM REPORT
OF THE
SENATE SPECIAL COMMITTEE
ON
SUICIDE PREVENTION

RECOMMENDATIONS

PRELIMINARY COST PROJECTIONS

February 10, 1988

Alaska Department of Education

Summary

FY 90

Suicide Prevention Recommendations 1.1 and 1.2:

1.1. Each school needs to identify and implement a mechanism for identifying seriously troubled youth and referring them to the appropriate helping agency.

1.2. Each school should develop a crisis response plan and a trained crisis intervention team which includes school personnel and community helpers.

Response to Suicide Prevention Recommendations 1.1 and 1.2

Training of Core Teams	$1000.0
Lead Counselors	4200.0
Teacher/Counselor Training	35.0
Community Planning	300.0
School Counselors	15521.0
School Counselor/Village Aide Program Development Project	90.0
Administration and Coordination	113.7
	21259.7

Suicide Prevention Recommendation 1.3.:

1.3. Each high school and junior high school needs to include in its regular curriculum a program in "emotional survival skills" that is developed to help young people understand and constructively cope with stress, negative feelings, and difficult decisions. It is in the overall context of this program that youth should be informed about suicide, its warning signs, appropriate ways to support a troubled friend and when and whom to call for professional help.

Response to Suicide Prevention Recommendation 1.3

Model Life Skills Curriculum	62.8
Training in Use of Curriculum	36.0
Awareness Video Program	30.0
Specialized Trainers	15.0
Parenting and Child Development Course	117.8
Administration and Coordination	183.7
	444.5

Suicide Prevention Recommendation 1.4.:

1.4. Young people are mostly likely to share their feelings and problems with their peers. The ability of peers to support and assist each other can be enhanced through special training. The Natural Helpers program has proven effective in identifying and training peer support net- works when on-going, consistent adult support and guidance is available. The Department of Education needs to encourage all high schools in Alaska to implement the Natural Helpers Program and to formalize the role of the adult staff member who supervises the program.

Response to Suicide Prevention Recommendation 1.4

Natural Helper Program	
1.Initial Training for Staff and Students; Part-time Contract/Release Time for Key Lead Teacher/Counselor in Each School Duplication/Dissemination of Materials	590.0
2. Additional Resources	75.0
3. Administration/Coordination	145.4
	810.4

A. Response to SUICIDE PREVENTION Recommendations 1.1 and 1.2:

1)	Training of Core Teams. a) Crisis Response Teams (CORE Teams) trained in detection of abnormal behavior that identifies students deserving more indepth attention, techniques for intervention and assistance, et.al. To initiate program statewide, training sessions of 4 days, with approximately 40 participants per site would be required: CORE Teams in 55 School Districts + Mt. Edgecumbe $1,000.0	$1000.0
2)	Lead Counselors. a) Counselors hired by each District to act as lead and provide direct services for students - minimum $4,200.0; This provides only 1 counselor per district; additional resources would be necessary to provide focused counseling services at each public school.	4200.0
3)	Teacher/Counselor Training a) Intensive training for volunteer teachers to assume responsibility for providing discussion groups, referring severely troubled youth, information on coping skills, et.al. (3 urban training sites) $135.0	35.0.
4)	Community Planning. a) Community Planning to provide basis for community/school response to crisis situations affecting community youth including suicide, violent death and other traumatic events; Cost factors include time for selected school district personnel to act as lead for district (3 weeks minimum per school year), publication and distribution costs of model protocols, effective programs developed elsewhere in Alaska and the U.S. Total cost est. for planning initiates at the school district level: $300.0	300.0

(cont.)

5)	**School Counselors.**	
	a) Restore or increase the number of school counselors in the public schools.	
	1.Elementary schools - one half time counselor per elementary and multi-grade (K-12) schools (371 x $31.0)	11501.0
	2.Middle and secondary schools - one full time counselor per middle and secondary school in the state(67x$60.0)	4020.0
6)	School Counselor/Village Aide Program Development Project	
	a) Researh and evaluate potential of school counselor/village aides training program similar to Community Health Aide program. Work with the University of Alaska and rural communities to develop training program.	90.0
7)	Administration and Coordination.	113.7
	a) Salary and benefits (State Counseling Specialist) (58.2) (Half-time Clerical Support) (14.0)	
	b) Travel (5 conference/workshops x $800) (4.0) (5 training sessions x $800) (4.0) (1 outside conference x $1100) (1.1) (3 agency meetings x $800) (2.4)	
	c) Contractual (phone/postage) (10.0) (publications/newsletter) (15.0)	
	d) Equipment (5.0)	

TOTAL
$21259.7

B. Response to SUICIDE PREVENTION Recommendation 1.3:

The focus of this K-12 curriculum will be on wellness and prevention. Specific topics will include but not be limited to the following: parenting, commmunication **and decision making, self-concept building,** family violence, education about **sexuality, gender roles and sex stereotyping,** sexually transmissible diseases and AIDS, prevention of date rape, sexual abuse and substance abuse, dealing with family dissolution, dealing with grief, job application skills such as resume preparation, job interviewing, and how to be a responsible, dependable worker, and similar topics.

1)	Model Life Skills Curriculum.	62.8
	a) Statewide Task Force to develop curriculum life skills guide	
	1) 12 people x 3 meetings (x $600/mtg/person) (21.6)	
	2) Audioconferences (1.2)	
	3) Facilitator (Honoraria - Travel) (5.0)	
	4) Phone/Support Costs (10.0)	
	b) Publication/dissemination of model guide (25.0)	
2)	Training in use of curriculum - Training of Trainers approach (one trainer/district).	
	a) five day summer workshop, June, 1989 $600/participant - travel + per diem x 55 districts (33.0)	36.0
	b) honorarium for trainers 2 x 1.5 travel and per diem (3.0)	
	c) on-going university courses/workshops	
3)	Awareness video program--how to use the curriculum which is "the integrated approach to high risk."	30.0
4)	Add specialized trainers from other agencies, non-profits, local communities to D.O.E. Talent Bank.	15.0
	a) Support for honoraria for them to work with school districts	
5)	State School Board policy adoptions review.	0.0

6) Pilot Parent Programs. 117.8

a) Piloting of comprehensive parenting program in 4 sites: 2 rural, 2 urban communities (Parent Focus) (77.0)

b) Pilot a semester parenting and child development course in junior high/senior high in four school sites (40.8)

7) Administration and Coordination. 183.7

a) Personnel
  1) Health Education Position - coordinator at state level. Salary and benefits (46.1)
  2) Associate for Dissemination of Materials (20.0)
  3) Half-time Clerical support (15.0)
  4) Training and Materials Development Specialist. Salary and benefits (51.4)

b) Travel
  (8 trips to conduct training $800/trip) (8.0)
  (3 trips to outside conference × $1.2) (3.6)
  (4 trips to 4 pilot sites $800/trip) (3.2)
  (4 presentation state conferences $800/trip) (3.2)
  (5 agency meetings $800/trip) (4.0)

c) Contractual
  (10 audioconferences × $320) (3.2)
  (phone/postage) (20.0)

d) Equipment (6.0)

TOTAL $ 444.5

Betty J. Claymore, Ph.D.
Area Mental Health Program Officer
Aberdeen Area Indian Health Service

SENATOR INOUYE, MEMBERS OF THE SELECT COMMITTEE ON INDIAN AFFAIRS:

The Aberdeen Area Indian Health Service is pleased to participate in your oversight hearing to address community based initiatives to meet the mental and emotional health care needs of American Indian and Alaska Native people.

The Aberdeen Area Indian Health Service Office, Aberdeen, South Dakota has within its service delivery population about 80,000 Indian people. Seventeen tribes are represented and their members are served by health center and hospital units located in North Dakota, South Dakota, Nebraska, and Iowa. We are authorized a total of 47 full time mental health positions, 81 percent of which are staffed by Native Americans. We have developed a support cadre of consultant psychiatrists and psychologists through use of contract health resources and are assisted in providing mental health services by physicians, nurses, health educators, community health representatives, and alcoholism programs under the authority of Indian Self Determination Policy as described in P.L. 95-638. Bureau of Indian Affairs Social Services, Division of Education, and Law and Order personnel work closely and cooperatively with us. Our programs interface with various state mental health programs and regional mental health centers. Services provided are primarily outpatient except for our 10 bed acute care unit located at Rapid City PHS Indian Hospital for voluntary patients which primarily serves patients from the Aberdeen, Billings, and Bemidji Areas. Involuntary commitments are referred to state hospitals.

The most prominent feature of our outpatient care is that it is crisis oriented and includes 24 hour response systems to address patients who present as victims or perpetrators of interpersonal violence. Quite commonly, this violence may take the form of spouse abuse, a suicide attempt, or in response to situations in which children are physically or sexually abused. In addition, we have responsibilities to assess, diagnose, treat, and monitor seriously disabled mentally ill adults. Stressful and limiting economic conditions of reservation environments and high rates of unemployment and alcohol abuse contribute to our major treatment categories of anxiety and depression. Service delivery for all health services in this part of the country is characterized by a shortage of professional health care personnel, great distances between clients and resources, and difficulties in communication due to lack of telephones and motor vehicles. Both federal and state mental health service delivery systems are unsophisticated and underdeveloped. Staffing patterns provide for minimal coverage and most reservations consist of one masters level social worker and one technician. Being responsible for 7 day a week call often leaves staff exhausted and without energy to promote community involvement and prevention. Fifty-two percent of our population is 19 or under so using NIMH expectancy rates, we estimate that we may have 5,000 children with serious mental disturbances. Identification and early intervention for this population is a key topic of discussion of conferences where mental health needs are debated.

The following actual examples are meant to be illustrative of typical service delivery programs and are intended to give depth to your exploration of the severity of mental health problems, the scope of needs, and the staff capabilities:

Reservation "A' has a service population of 6,800 who are served by a staff of one MSW and one paraprofessional. The Service Unit has added a temporary paraprofessional primarily to assist in child abuse and neglect work, assist with third party payments, and help with the weekly partial care program. The program has no secretary so professional staff complete their own reports and perform other non-professional tasks such as answering telephones. The program is located in three small hospital rooms without windows in an area which was formerly a laundry storage room. It does not meet program standards for space or windows. A psychiatrist provides consultation two days a month. In addition to usual crisis intervention services, this program has established a partial care program for 11 dual syndrome (chronically mentally ill and chemically dependent) patients. This program operates out of the hospital conference room one day a week. Medications are monitored and there is a support group, recreational therapy, and health education all provided or coordinated by this small staff. A Goodwill type store has been established in a nearby tribal building so that the patients will have some form of part time employment. An estimate of patient and consultant contacts for this staff is 750 per month. Staff members serve on the following committees: interagency, child protection, P.L. 142 Special Education, BIA school disciplinary, tribal action plan, fire and safety, utilization review, and contract health care. They also coordinate all services for a domestic violence grant program, assess and testify for the mental illness and alcoholism board, and operate the EEO, the Federal Women's Program, and the Employee Assistance Program for the benefit of hospital staff of 65.

Reservation "B" has a service population of 4,268 and actually represents two tribes served by one IHS health center. There is currently one IHS social worker and one tribal mental health technician both located at different sites. A consultant psychologist provides assessment and evaluation services. There is no psychiatrist available although a position has been established through new clinic staffing. Recruitment efforts to fill this position have been unsuccessful for approximately one year. The salary for the psychiatrist is set at $50,000 which is less than half that paid for a psychiatrist at the state hospital. The MSW is serving on two child protection teams and two suicide task forces, and one service. One community has been the focus for state and federal child sexual abuse investigations and prosecutions over the last two years. From this small community of approximately 25 families there have been 7 successful prosecutions, 7 children removed from their homes, and 8 additional cases are currently under FBI investigation. The state social service has done the home investigation component so it is expected that BIA social services and IHS mental health will take responsibility for evaluations and treatment of all victims and some perpetrators, particularly those who are minors and who have not been sentenced to prison. In this situation which has affected all families, telephone threats have been made against health care providers and clients who talk to them have been threatened or beaten. Our Joint Area Child Protection Team which is co-chaired by IHS and BIA works closely with all parties to coordinate resources and provide support. Suicide attempts by tribal members have been on the increase since April.

Reservation "C" is a large reservation with a service population of 17,583. This program was the IHS pilot mental health program and consequently has a larger staffing pattern than all of our other programs. It is staffed with one MSW, one psychologist, one psychiatric nurse, five mental health technicians, and one secretary. A psychiatrist and a psychiatric nurse from the regional center consult monthly. Mental Health has had difficulty in being accepted as a holistic part of the health care program by both community and other professional staff. The program has changed its name to Human Service Center since they feel local people do not like the term "Mental Health". Local medical staff have not been trained in psychiatric settings and feel that that because of their overwhelming clinical responsibilities they do not have sufficient time to become trained and involved in the care of mental health patients. A local study showed 90 patients who qualified as chronically mentally ill by state standards. This reservation accounts for 60% of IHS involuntary admissions to the state hospital. IHS currently must pay $700,000 per year to the state of South Dakota for involuntary hospitalization of mentally ill Indian persons pursuant to the White vs. Califano decision. In February 1988 the Attorney General for the State of South Dakota reinterpreted other provisions of that same decision making it necessary for our staff and the tribe to promptly hold 9 recommitments hearings from reservation "C" and 13 rehearings from other South Dakota reservations to prevent patients who were a danger to themselves or others from from being discharged and returned to tribal jurisdictions. There is no facility other than the jail to hold patients approximately 5 days until a due process hearing can be held. It is not unusual for there to be as many as 4 mental health patients in jail. There could be juvenile suicide attemptors as young as 12 years of age and due to cell space patients may be mingled with other inmates and held under harsh and inhumane conditions. According to national data, suicide rates in jails exceed non-jail rates more than 3 to 1. While this reservation has the greatest number of people affected, several other reservations also routinely use their jails for patients requiring security and protection because they have no mental health facilities for this purpose.

Past experiences [illegible] lead some Indian persons to believe that most experts reside off reservation. Sending children off to boarding schools, medical patients [illegible] regional centers, mentally retarded off to state institutions, and [illegible]ally ill to state mental hospitals is generally accepted practice. [illegible]ervation residents will recall the community action programs of the la[illegible]'s which were just beginning to be taken seriously to show impact on [illegible]nity development when they were discontinued.

Community based programs in the Aberdeen Area which should be noted are Patch (COC's planned approach to community health), Groundswell, a prototype training program for tribal leaders on how to motivate communities to make lifestyle changes, and Project Reach, a health net concept which promotes linkages of pre-existing agencies and resources and some service penetration into Indian communities.

In conclusion, currently existing mental health services to Native Americans have not increased commensurate with need and are grossly inadequate. One should learn from the deinstitutionalization movements of the 50's that programs for home based consumer services and less restrictive environments require commitments by communities and that advance preparation of communities by community development oriented program specialists assisted by program planners is essential. Time and major resource commitments are additional basic elements required for implementation. Tribal willingness, readiness, and prioritization, should be an important consideration in implementation since tribes are now being beseiged with a large number of self help propositions by other federal and state agencies. We do believe that ultimately, tribally-operated community based mental health services would be desirable and superior to current delivery systems. However, there should be no immediate expectations that they will impact favorably on current operating costs or that reallocations of meager resources will be cost effective.

I wish to thank you for this opportunity to describe our services and present our concerns. We appreciate your interest and efforts on behalf of the Native American people we mutually serve. If you have any questions, I will be pleased to answer them.

Floyd L. Jennings, Ph.D.
Director, Mental Health Programs
PHS Santa Fe Indian Hospital
Santa Fe, New Mexico

US Senate Testimony
7 July 1988

INTRODUCTION:

The mental health needs of the Indian population in the United States have been well documented in these proceedings and need little reiteration regarding suicide rates, prevalence of alcoholism, or family violence; not to say more traditional psychiatric disorders.

I am assigned to the Santa Fe Service Unit, Santa Fe, New Mexico; where my position is that of Director of Mental Health Programs. The Santa Fe Service Unit serves twelve tribal units in northern New Mexico - an area from Albuquerque north to the Colorado border - and an Indian population of some 17,000. The Service Unit includes a 55 bed hospital in Santa Fe; three health centers in Taos, Santa Clara and Dulce; and four satellite clinics.

The catchment area served by the Santa Fe Service Unit is geographically and culturally diverse so that not only must mental health programs represent the highest level of technical and professional competence, but must also honor (and utilize) traditional healing principles, and community values.

Mental health programs are community based: In our setting are some three doctoral level IHS psychologists, four mental health technicians from the tribal communities, eight contract consultants, and a single secretary. In one community alone, where over 16 suicide attempts and 3 completions have occurred since January 1, 1988 through mid-June, we face a difficult task with limited personnel resources. In that community we have but one mental health technician, and one part-time contract consultant, with limited consultative support from the service unit and area staff.

PROGRAM NEEDS

The multiplicity of needs within this limited geographical area are of such magnitude that serious description meets with incredulity. Larger public health needs notwithstanding, the mental health needs alone are staggering. Statistical representation does not adequately convey the tragic elements in suicides by 14 year-old, male, adolescents whose parents are so immersed in their own alcoholism that they do not discern the nature of the child's needs. Tabular presentation of data, however carefully formatted, does not convey the tragedy of a 16 year-old female, pregnant with her third child, already having borne a child damaged by fetal alcohol syndrome, and now ill with pelvic inflammatory disease as well as multiple substance abuse problems. And perhaps even more tragic is the picture of a community whose anomie is such that many of its citizens, if not most, are inured to the plight of the young.

Were not the foregoing sufficient, the limitation on resources within IHS requires prioritizing responses in a difficult manner: A governor and lieutenant governor of one pueblo plead for two full time staff persons to aid in health promotion, and in providing community mental health education, as well as direct services; however, budgetary constraints are such that rather than two persons for one pueblo, three pueblos must share the time of a single staff person.

PROGRAM RESPONSES

Unusual problems require creative and unusual solutions, maximization of personnel resources, utilization of supplemental contract funds, and extending the functions and power of non-physician care-givers. Creative solutions often do not easily lend themselves to quantitative measures, though funding is usually attached to "hard" data. Much more difficult to quantify is time devoted to development of in-direct services (e.g. providing support and assistance to tribal units in writing of grants to tap alternate funding sources), as well as major emphasis upon health promotion and/or primary prevention activities.

Despite the employment of all creative efforts, there are finite limitations upon the extent to which resources can be stretched. Consequently, the Committee is encouraged to lend the strongest weight toward increased support for integrated mental health services. The operative word is "integrated"; for fragmentation of programs and targeting of special populations with short-lived funds are rarely helpful. Free-standing alcohol programs without medical input and with a separate administration apart from mental health structures, may be theoretically or politically desirable, but pose many problems for implementation at the local level. Programs that target special populations, e.g. sexually abused children, may salve the conscience of some, but unless supported by long-term financial and personnel commitments, do little to impact community standards and behaviors.

Moreover, we have far more resources to identify problems than to treat them. For example, despite the many requests for IHS adolescent facilities that combine psychiatric and substance abuse treatments, there are none available within this area. The suggestion to establish liason with state programs and facilities is empty, and a cruel mockery of realistic assistance. It has currency only at a bureaucratic level far removed from patient care - because there are no state programs that are realistically available. What programs do exist are not relevant to the rural areas in which most of our patients reside.

As an administrator at the local level, I wish only for long-term financial and programmatic commitments on a congressional level that will remotely approach the dedication and commitment of the staff whom I am privileged to support, and the patients whom I am privileged to treat.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandur

July 15, 1988

Phyllis Old Cross, RN, MS
Rapid City SU

Testimony submitted to Senate Select Committee on Indian Affairs

RE: Indian Mental Health

My name is Phyllis Old Dog Cross. I am a registered nurse with a Masters Degree in Nursing. I work as a nursing consultant with the Regional Mental Health Program, PHS Indian Hospital located at Rapid City, SD.

The Regional Mental Health Program was mandated by P.L. 437 in 1978. It was designed on a community mental health model. It has all 5 components of mental health service delivery. These include 9 inpatient beds, outpatient, consultation and education and 24-hour emergency services. The program has 9 states in the catchment area but we have served patients from as far away as Washington State and the East Coast. Since 1982 we have served the total of 1,100 inpatients. About 1/3 of the inpatients are referred from the Pine Ridge Indian Reservation and about 25% are referred from Rapid City. The rest come from other reservations. Of all the admissions to inpatient services about 45% are Psychosis, 18% Personality Disorder, 28% Affective Disorders and about 9% with other diagnoses. Of all the inpatients admitted about 70% have alcohol abuse problems and would be considered dual diagnosis patients. We have an 81% bed occupancy rate with an average length of stay of 17 days. Our total staff time spent on inpatients is 1/3.

We see approximately 250 outpatients a month. If we see families we count them as one unit so we actually see more people. We provide 24-hour emergency service, we consult with other reservations. I focus the consultation I do on family violence, child sexual abuse and child abuse.

From my observations our greatest problems in mental health are:

1) Chronically mentally ill. They need more service, many are homeless and rejected by their families and reservation. There are no halfway houses or programs and tend to be a hidden and neglected population.

2) Family violence. Violence in the family is exploding on reservations. Child sexual abuse is a great problem and causes many mental health problems as sequelae. The rates of homicide and suicide are increasing rapidly as are incidents of battering of women and children.

3) Child sexual abuse. The sexual abuse of infants and children is epidemic. This problem is frequently connected to alcohol abuse in the family.

4) Adolescent acting out. We are seeing increased acting out of adolescents as part of family violence patterns. This includes alcoholism, sexual abuse, homicide and suicide.

5) Mental health services in IHS tend to be dealing only with emergencies and many of our services are bandaide in nature. Some of our service units are like mash units on weekends, dealing with alcohol related violence and problems.

I would like to offer the following suggestions.

1) We need to revise our treatment approaches to dealing with the family. Most problems occur in a family setting and we need to change from individual treatment to the entire family focus.

2) We need to focus on causes of mental health problems and become more concerned epidemiology and prevention.

3) Indian people, community and leadership must be more involved and responsible for finding solutions.

4) Services to Indians must be better coordinated. At present, rivalries between various programs on reservations such as alcohol treatment and Mental Health services are counter productive.

5) More accountability and quality assurance must be integrated into service delivery.

6) Indian persons must be afforded opportunity for education in Mental Health fields and incentives provided to keep them at reservation level.

Phyllis Old Dog Cross RN MS

Phyllis Old Dog Cross, RN, MS
Psychiatric Nurse Consultant
Sioux San PHS Indian Hospital
3200 Canyon Lake Drive
Rapid City, SD 57702

RECEIVED
8-29-88

IDENTIFICATION

My name is Marian Estelle Zonnis.

I am a graduate of Washington University Medical School, St. Louis, Mo. (1936). I am Board Certified in Psychiatry, the American Board of Psychiatry and Neurology (1946).

My professional experience prior to entering the Indian Health Service (October, 1972) has included part time private practice in the medical specialty of Psychiatry plus variable length part time clinical positions in Veterans Administration Out Patient Clinic (Detroit, Michigan), Youth Detention Home (L. A., CA.), Child Guidance Clinic (Palm Springs, CA.), Consultant, Palm Springs Unified School District (Palm Springs, CA.), Psychiatric Clinic, Student Health Service (UCLA, CA.). I have also given extension courses on mental health matters at U. C. Riverside and U. of Northern Arizona.

Since 1972, I have been employed full time by the Navajo Area Indian Health Service. Initially I provided clinical and consultant psychiatric services at various Navajo Area service units. For the past several years I have been director of the Navajo Area Mental Health Branch. In this role my work has been largely administrative, including program planning, management of a line item budget, recruitment, consultation and coordination with the Service Unit Mental Health staffs in matters such as training, quality assurance, Health Promotion/Disease Prevention activities (HP/DP), personnel concerns, employee assistance counseling, community liaison, networking with Tribal entities, including alcoholism, Tribal Social Service, Law Enforcement, citizens and community groups of various interests, as well as relating to state and national agencies, particularly IHS Mental Health Headquarters.

The Mental Health Branch
Navajo Area Indian Health Service

The Navajo Area consists of a population of 180,000 Native Americans in a space of approximately 25,000 square miles.

The Navajo Area Mental Health Branch consists of 47 positions and has a line item recurring budget of $1,726,500 (FY 1988). These positions are distributed in 8 Service Units in the form of Mental Health Clinics. There are clinics in 6 hospitals (3 in New Mexico, 3 in Arizona), in 2 major health centers and in health stations all on a full time basis. Additional service clinics are held part time at field health stations.

There is an in-patient Mental health Ward of 13 beds funded by Hospitals and Clinics budget consisting of a staff of 19. This ward servers as a regional mental health resource.

There is, in addition, a Child Psychiatric Team centered in Gallup consisting of 4 persons.

The staff of the Mental Health Branch is multi-disciplinary. Because there are not enough positions for all disciplines at each service unit there has been a regional concept employed in which multidisciplinary teams are present in each region.

Some features of staffing include the presence of 1 or more psychiatrists at each service unit who act as part of the medical staff as well as manageing their respective mental health clinics. There has been emphasis on upgrading staff positions to Mental Health Specialists and employing Navajo professionals. There are 11 bi-lingual professional positions. All Mental Health Technicians and secretaries are likewise bi-lingual. With the increase in Tribal and community support services, the functions of the Mental Health clinics assume more of a role in community education, initiating and participating in community mental health activities.

All of our clinical resources are strained. There are some 30,000 patient contacts in a year involving 12,000+ persons and numerous community contacts, in-service training, and consultative, liaison and networking activities.

Some of these activities include a videotape production on teen depression, a wilderness therapeutic retreat for teenagers, a psychodrama workshop, a spiritual reteat, the creation of a detailed community catalogue of human service, spearheading women's shelters, a school program focussed on families of disturbed teenagers, participation on Child Protection Teams, alcoholism programs, parenting classes, jail clinics and numerous others.

All of this is conducted in a setting that is marvelously beautiful. The population however suffers unduly from 1) a lower life expectancy than the national average, alcoholism, unemployment, poor roads, many problems with cultural confusion and diffusion. Youth show serious problems with substance abuse, depression, suicidal behavior, a high dropout rate in high school and college, a lag in all school years compared with other segments of the population, a diminished self-esteem and often a demoralized dim view of the future.

There are hidden strengths such as traditional close family and clan supports. Traditional ceremonies are in source of strength and pride and an unknown but significant number of persons find help thru traditional healers. Gradually over time role models employing the best of two cultures emerge.

One of the most important mental health program needs in the Navajo Mental Health Program is for additional mental health services to children. A pilot Child Psychiatric Team consisting of a child psychiatrist, a child psychologist, (currently vacant), a psychiatric social worker (Navajo speaking) and a secretary constitute the Team. This team has been overwhelmed by requests from outlying Mental Health clinics and various Tribal and community entities. Because of enormous problems facing Navajo children and adolescents including alcoholism, family violence, sexual abuse and neglect there are numerous instances of substance abuse, violence, teenage pregnancy and school dropouts. Of great significance is the fact that overall school performance lags state averages from second or third grade on. This promotes feeling of inadequacy and lowered self-esteem in later competitive situations, most importantly related to employability.

Another major need is to develop a cadre of Navajo Mental Health staff trained and competent in leadership roles. In due time it is likely that the Mental Health Program will be contracted by the Navajo Tribe. We believe that it is highly desirable that at that time there be in place a creditable, experience group of Navajo Mental Health Specialists equipped to transfer the program without loss of efficiency and effectiveness. A sample of this is the leadership assumed by a field Navajo Mental Health Specialist in organizing a five-day therapeutic wilderness experience for teenagers. Another example is the court clinic regularly held for teenagers initiated by a Mental Health Technician. The third example is the gradual development of one of our Mental Health Technicians who has attained a Master's degree in counseling psychology and now is the director of a major health center.

A third need is for increased inpatient mental health service because the Navajo reservation is isolated, access to adequate numbers of inpatient mental health treatment beds is difficult. therefore, we are exploring the possibility of gaining additional mental health beds as IHS facilities are renovated and/or expanded. At Fort Defiance there will be 20 adolescent psychiatric beds to serve the Fort Defiance region. There is also a plan to create a 30-bed alcohol substance abuse facility at Shiprock, New Mexico using alcohol Omnibus money.

There are numerous potentialities for innovative and creative activity in the Navajo mental health program. We are fortunate in having a committed and effective staff to carry out these goals.

CONTRACT CARE COSTS FOR INPATIENT MENTAL HEALTH CARE
BY HOSPITAL TYPE AND DIAGNOSTIC CATEGORIES
FY 1987

ALL HOSPITALS

ICD9-CM	DISCHARGES	DAYS	COST
290	6	51	7,658.59
293-303	385	4,113	825,188.51
306-316	205	2,912	470,651.79
Totals ALL Hosp.	596	7,076	$ 1,303,498.89

GMS HOSPITALS (01)

ICD9-CM	DISCHARGES	DAYS	COST
290	6	51	7,658.59
293-303	308	2,275	624,616.82
306-316	149	1,395	322,660.85
Total 01 Hospitals	463	3,721	$ 954,936.26

NEURO-PSYCHIATRIC HOSPITALS (03)

ICD9-CM	DISHCARGES	DAYS	COST
290	-	-	-
293-303	77	1,838	200,571.69
306-316	53	1,441	136,555.14
Total 03 Hospitals	130	3,279	$ 337,126.83

OTHER HOSPITALS (04)

ICD9-CM	DISCHARGES	DAYS	COST
290	-	-	-
293-303	-	-	-
306-316	3	76	11,435.80
Total 04 Hospitals	3	76	$ 11,435.80

SOURCE: ON-REQUEST-REPORT #19, DATED 6/30/88 MHPA&R 7/29/88

CONTRACT CARE COSTS FOR OUTPATIENT MENTAL HEALTH CARE
BY DIAGNOSTIC CATEGORIES
FY 1987

ICD9-CM	CONTACTS	COST
290	30	1,980.00
293-302	1,147	75,702.00
306-316	1,180	77,880.00
TOTAL	2,357	$ 155,562.00

The outpatient medicare billing cost was used to convert workload to dollar cost.

SOURCE: CHS REPORT #3A DATED 6/24/88, MHPA&R 7/29/88

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